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GUIDELINES FOR HEALTH PROMOTION & EDUCATION SERVICES IN HMOs

PHYSICIAN SERVICES

HOSPITAL SERVICES

EMERGENCY HEALTH SERVICES

MEDICAL TREATMENT & REFERRAL

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES/PUBLIC HEALTH SERVICE

HEALTH PROMOTION & EDUCATION SERVICES

- MEMBER ORIENTATION & RELATIONS
- PATIENT & FAMILY EDUCATION
- MEMBER HEALTH EDUCATION & COMMUNITY/WORKSITE OUTREACH
- ORGANIZATION DEVELOPMENT & INSERVICE EDUCATION

A

GUIDELINES FOR HEALTH PROMOTION AND EDUCATION SERVICES IN HMOs

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

Office of Disease Prevention and Health Promotion
Office of Health Information, Health Promotion and
Physical Fitness and Sports Medicine

with the

Centers for Disease Control
Center for Health Promotion and Education

and the

Office of Health Maintenance Organizations

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FOREWORD

HMOs are a special form of health care delivery not only because of the cost savings they achieve but because of the opportunity they offer for provision of preventive and health education services. They have been leaders in providing education on the use of health services, in reaching out to high risk groups to achieve early entry into care, in helping their members select and maintain healthier lifestyles, and in reducing the toll of chronic illness through patient and family education.

A previous edition of these Guidelines appeared in 1976. *Planning Health Education in HMOs* was widely distributed until last year. Because that edition was becoming outdated and because numerous HMOs had requested more extensive technical assistance, the Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine, the Center for Health Promotion and Education, and the Office of Health Maintenance Organizations decided to collaborate on a second edition. Drs. Mullen and Zapka were asked to draw on their experience and expertise in health education programming in HMOs and to enlist the assistance of experts from HMOs throughout the country in preparing the new Guidelines.

This edition reflects the expanding knowledge base, the larger body of protocols and documents from well-established HMO programs, the new spotlight on disease prevention and health promotion. The title of these Guidelines was expanded to capture the spirit of the new term, "health promotion."

I would particularly like to express my appreciation to Dr. Lawrence W. Green, Mr. Horace G. Ogden, and Dr. Frank H. Seubold, directors of the sponsoring offices. I think they have produced Guidelines that will be of great value to both new and established HMOs in strengthening health education and promotion services.

Edward N. Brandt Jr.

Edward N. Brandt, Jr., M.D.
Assistant Secretary for Health

PREFACE

The HMO Act of 1973 (P.L. 93-222) specifically mandated HMOs to encourage and actively provide for their members health education services, education in the appropriate use of health services, and education in the contribution each member can make to the maintenance of his/her own health. Now with over 9 million persons receiving care in 236 HMOs, HMOs have proven themselves to be a viable concept; so too has health education. As HMOs continue to grow and thrive, the "how's" of expanding health education services are of interest to HMO managers and medical directors. This document is a practical and comprehensive guide to effective programming.

I applaud the efforts of the authors, and I thank all those individuals who contributed.

Frank Seubold

Frank H. Seubold, Ph.D.
Director
Office of Health Maintenance
Organizations

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Many health education directors, administrators, and medical directors from HMOs throughout the country contributed to the development of these guidelines. We received valuable suggestions about content, format, and structure; constructive dissent; and a variety of forms, protocols, and reports. In addition, staff members from the co-sponsoring Federal agencies were enormously helpful in a variety of tasks.

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ADVANTAGES OF PLANNED HEALTH EDUCATION AND PROMOTION PROGRAMS

- **From a member perspective**
  Planned programs contribute to improving the health of members. Coordination of educational activities assures consistency of messages from the various providers and in written materials. Improved communication skills of HMO staff increase member satisfaction.
- **From a professional perspective**
  Planned programs improve patient outcomes by promoting adherence to therapeutic regimens and by encouraging and guiding self-care and healthier lifestyles. Timely presentation of problems, greater self-reliance, and understanding of HMO procedures on the part of members make the professional's job easier.
- **From a marketing perspective**
  Health education programs represent an increasingly attractive benefit not provided by many other health insurance plans. Response to the increasing demand of business and community groups for health promotion programs improves the HMO's competitive position.
- **From a management perspective**
  Organized education achieves better utilization of HMO services (e.g., by reducing no-show rates). Planned programs also use personnel optimally by distributing educational functions appropriately and aggregating enrollees/patients. Systematic approaches increase accountability for program quality.
- **From a legal perspective**
  Planned programs contribute to informed consent and help protect the organization from that proportion of malpractice litigation resulting from poor communication and dissatisfaction.
- **From a licensure perspective**
  Planned programs satisfy the legal mandate for health education benefits in those states that require it. (Part 1 of the appendix gives the State of California's statute and regulations.)
- **From an accreditation perspective**
  Planned programs provide a means to meet patient education, patients' rights, and professional continuing education criteria outlined by various accrediting bodies.
- **From a community relations perspective**
  Many human services programs have been challenged to provide services to the general community in addition to programs for their constituency. Programs can be opened to nonmembers at little or no additional cost to the HMO to help meet this demand.

EXECUTIVE SUMMARY

Health education and promotion are services of increasing importance to HMOs as we enter the 1980's. When the HMO Act was enacted in 1973, the benefits of health education were largely theoretical, reflecting the lack of funding for rigorous evaluations and reliance on medical technology as the primary means of achieving improvements in health. Now, nearly 10 years later, recognition of the limits of technology and of the importance of environmental and behavioral factors in the health equation is beginning to transform our thinking about health care.

This document was written to help answer the questions being asked by HMO administrators, medical directors, and boards of trustees: What exactly is the definition and scope of health education and promotion? How effective are these services? How are programs best organized? What are the administrative issues that must be taken into account? And, how is the quality of an HMO's health education and promotion programs assessed?

A health education and promotion program is a combination of motivational, organizational, and environmental activities designed to support behavior conducive to the health of members. Health education and promotion programs can make substantial contributions to HMO goals separately or as an integral part of other services by: 1) promoting appropriate use of services, including early response to warning signals; 2) encouraging member participation and involvement in advisory, policymaking, and other voluntary service roles; 3) improving self-care skills for the treatment of minor acute problems and for managing chronic and other long-term illnesses and disabilities; and 4) preventing disease and promoting well-being. Other benefits of achieving these goals include improved member satisfaction, increased enrollment, higher staff morale, and improved interdepartmental and interagency communication and cooperation. Usual approaches include member orientation and relations, patient and family education, member health education, and outreach to community and worksite. Organization development and inservice education are cross-cutting strategies to improve the overall educational effort.

There is evidence that health education and promotion programs work. The strongest part of the knowledge base is the significant and positive effect of patient and family education on adherence to therapeutic regimens. Certain specific areas of risk reduction and self-screening for the well population are also documented, notably, smoking cessation groups. Self-care education for particular conditions has had success in reducing utilization of services. Although relatively few comprehensive studies have been conducted to test orientation programs, there is evidence that they are effective in helping HMO members understand and follow recommended procedures, including periodic health screening schedules. Likewise, there is evidence that organization development and staff training programs can help an HMO to function more smoothly and meet member needs and expectations more effectively.

The guidelines given here are intended to provide a frame of reference for the decisions managers of individual plans will make about program directions and methods. Essential elements for effective program development are

1. Needs-assessment—Just as diagnosis is the basis of a medical treatment plan, needs assessment or diagnosis is essential to educational planning. Many sources of information can be drawn upon: State and local health and risk factor data; feasibility study data; operations data; systems analyses; information from consumer surveys, provider surveys, and advisory groups; and community resources and inventories of on-going programs and activities in the HMO.

2. Establishment of priorities—It is important to know not only which health problems and risks affect members but their magnitude, the probability of affecting change, the cost/benefit ratio of the effort required to bring about the change, and the readiness within the HMO to initiate and support the program. These will be the basis for setting priorities and developing a long-range plan.

3. Program design—Analyzing causal factors, setting program objectives, deciding on an appropriate level of effort, selecting an appropriate mix of educational and organizational approaches, and timing and incentives are all matters to be considered.

4. Administrative support—Just as important as expert programming are administrative decisions that will determine the viability of the health education and promotion function in the HMO. Realistic expectations about the amount and rate of change and about the time necessary to plan a program need to be set. The support and sponsorship of high level decisionmakers are crucial to ensuring that the health education and promotion director can draw on components across the HMO. Organizational placement of the health education and promotion unit should also foster interdisciplinary cooperation. And, clearly, qualified staff in adequate numbers and with fiscal and other resources matched to the expected output are necessary to a successful program. The Guidelines outline staff functions and qualifications and present several sample job descriptions. Staff ratios from HMOs

throughout the country and budgeting and financing mechanisms, such as capitation and co-payments, are also presented.

5. Quality assessment—Approaches for health education and promotion programs parallel those for personal health services, and they are also interlinked. Thus, quality assurance methods include integration of educational criteria with other medical care audits, program documentation, program evaluation, external peer review, and professional review of health education and promotion staff and of the educational functions of other staff members.

DEFINITIONS

HEALTH EDUCATION AND PROMOTION PROGRAM:	In an HMO setting, it is a combination of motivational, organizational, and environmental supports for behavior conducive to the health of members.
HEALTH EDUCATION SPECIALIST:	A health professional with training and experience in planning, managing, and evaluating health education and promotion programs. In an organized program, a variety of professionals, including physicians, nurses, pharmacists, and therapists, will have health education roles as patient and family teachers and counselors.

INTRODUCTION

Organized health education and promotion are relatively new services in health care settings. They are also topics of increasing public and professional interest as we enter the 1980's. Many health maintenance organization (HMO) administrators and medical directors are asking how effective these services are and how health education and promotion components are best organized and developed. To answer these questions, the Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine, in consultation with the Office of Health Maintenance Organizations and the Center for Health Promotion and Education, has prepared this guide.*

We recognize that no single program model or set of goals will work equally well for all HMOs. Some HMOs are not yet at the break-even point. Others may be firmly established, but their health education components may not be equally well developed. For example, independent practice associations (IPAs), which represent a growing proportion of federally qualified HMOs, pose special challenges because of their geographical diffuseness and greater professional autonomy. With such differences in structure, resources, and needs in mind, our objective is to describe basic programmatic elements, raise common issues, and give practical suggestions and examples from HMOs.

Our audience is the administrator, the medical director, and the staff member responsible for health education and promotion programming. Our aims are to acquaint the administrator and the medical director with a range of appropriate functions and methods and to raise crucial administrative and operational issues related to developing and maintaining effective programs. This is not, however, a how-to manual. We assume that a professional trained in health education will be responsible for specific programming and implementation. Neophyte health education and promotion directors will be equally interested in administrative issues. We have directed the examples and followup suggestions principally to them. For those administrators and medical directors in relatively new HMOs, this guide will increase understanding of how to fit health education and promotion into the overall configuration of services. Early planning can help ensure smooth development of a successful program. For those in more mature HMOs, this guide will help improve program effectiveness.

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* This document supersedes *Planning Health Education in HMOs* by Roosen-Runge, prepared under contract with the Bureau of Health Education (1976).** An earlier document, *Health Education in the Health Maintenance Organization* by MacColl and Smith (DHEW, May 1974), is no longer available.

** Under the reorganization of the Centers for Disease Control, effective October 14, 1980, the Bureau of Health Education became part of the Center for Health Promotion and Education.

This document contains four chapters, which are followed by a variety of resource listings and examples. Chapter 1 suggests goals for health education and promotion programming appropriate to HMOs and gives a sampling of tested activities and strategies. Chapter 2 outlines a process for deciding program priorities and for planning specific programs. Chapter 3 raises important administrative issues about the organizational placement, staffing, and financing of health education and promotion units. Chapter 4 presents a quality assurance framework for health education and promotion programs.

The annotated bibliography lists specific publications and HMO reports. Finally, an appendix supplies detailed information and examples of materials, position descriptions, and record forms used in HMOs.

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STRATEGIES AND OBJECTIVES

Member Orientation and Relations

- Member education and organizational change to promote optimal use of services
- Activities and incentives to encourage use of services by high-risk members
- Recruitment, training, and design of feedback mechanisms to increase member participation

Patient and Family Education

- Education about medical procedures and therapeutic regimens to improve understanding and adherence
- Education to decrease stress during medical and hospital procedures
- Education and guidance to prevent disease, promote early detection, and facilitate developmental adjustments

Member Health Education and Outreach to Community and Worksite

- Education to improve management of common, minor ailments
- Education to assist people in adopting healthy behaviors and reducing risk
- Development of health education and promotion programs to reach contract worksites and HMO employees
- Participation with community groups to reduce safety and other environmental hazards and to increase health promotion facilities

Organization Development and Inservice Education

- Inservice programs and consultation to improve providers' educational skills and sensitivity to other cultures and lifestyles
- Design of operational systems to reinforce and improve health education efforts
- Organization development to improve staff satisfaction and working relationships

CHAPTER 1

HEALTH EDUCATION AND PROMOTION SERVICES AND HMO GOALS

The organizational structure and objectives of the HMO are uniquely suited to developing the special programs and services needed to meet the new challenges and demands of health care. HMOs can orient their members toward utilization patterns which may not have been encouraged by past experience with fee-for-service medical care. They can achieve savings by reducing not only the initial length of hospital stay, but also rehospitalizations for chronic conditions. The public expects HMOs to live up to their name by emphasizing disease prevention and health promotion.

In this chapter we highlight four primary HMO goals to which health education and promotion programs can make significant contributions. We discuss major program strategies and present examples of activities to illustrate the range and type of tools available to HMOs. We cite the evaluation literature, expert consensus, and standards of practice to suggest practical approaches and to acquaint the reader new to the field with effective approaches.

When the HMO Act passed in 1973, the case for the advantages of health education and promotion programs was largely theoretical. Because medical technology was still seen by most people as the primary path to health improvement, most health care professionals did not support education programs. Now, less than 10 years later, much has changed. Modestly increased expenditures on health education and promotion have led to more sophisticated program development and rigorous evaluations, and these are beginning to produce documentation of the efficacy and cost effectiveness of health education programs.

Many of these studies have been conducted in HMOs. Some studies were associated with other medical care organizations but are applicable to HMOs. We present the results of such studies within a framework that indicates where the knowledge base is strongest and where it is still developing. For example, patient education to improve adherence to regimens has received the most attention, and results of programs for hypertensives leave no doubt that significant gains can be made through education. There is, however, much less certainty about the effectiveness of counseling parents on the use of infant car seats.

With respect to some behaviors, state-of-the-art education programs have been found to be *efficacious* (i.e., to achieve an improved health outcome for those who accept the intervention), but not *effective* under natural circumstances with people who have varying motivation for change. In the case of smoking cessation groups, for example, the efficacy of such programs with motivated volunteers has been well established, but only a small proportion of smokers enroll. Programs designed to reach a larger percentage of smokers are the subject of several experiments currently in progress.

We will also draw on rapidly improving standards of professional practice (1,2,3,4) and on expert consensus on disease prevention, health promotion, and patient education measures (5,6,7,8,9,10) in making recommendations for health education programming in HMOs.

For example, *Promoting Health/Preventing Disease: Objectives for the Nation* (6) is the result of 2 years' work in securing opinion and comment from hundreds of public, voluntary, and private health groups; from public interest organizations and professional associations; and from sectors of the public not directly associated with health. The objectives are formulated around three major arenas of action: preventive health services, health promotion, and health protection.

- Preventive health services—high blood pressure control, family planning, pregnancy and infant health, immunization, and sexually transmitted diseases.
- Health promotion—smoking cessation, appropriate use of alcohol and drugs, nutrition, physical fitness and exercise, and control of stress and violent behavior.
- Health protection—toxic agent control, occupational safety and health, accident prevention and injury control, fluoridation and dental health, and surveillance and control of infectious diseases.

Objectives for the Nation sets out quantified statements for the attainment by 1990 of the five health goals (one for each broad age group) identified in the Surgeon General's Report (5), and represents a valuable planning document for HMOs in disease prevention and health promotion. In addition, it lists current status and trends, data sources and their relative strength, a variety of potential intervention measures, and the principal assumptions underlying the objectives; much of this is applicable to HMO planning.

Goals

Health education and promotion programs can make substantial contributions to HMO goals separately or as an integral part of other services by: 1) promoting appropriate use of services, including early response to warning signals; 2) encouraging member participation and involvement in advisory, policymaking, and other voluntary service roles; 3) improving self-care skills for the treatment of minor acute problems and for managing chronic and other long-term illnesses and disabilities; and 4) preventing disease and promoting well-being.

Other benefits of achieving these goals include improved member satisfaction, increased enrollment, higher staff morale, and improved interdepartmental and interagency communication and cooperation.

Strategies and Objectives

Usual educational approaches include member orientation and relations, patient and family education, and member health education and outreach to community and worksite. Organization development and inservice education are cross-cutting strategies to improve the overall educational effort.

Member Orientation and Relations

Utilization patterns can be improved through special attention to such groups as new enrollees, members with particular problems or grievances, members of special population groups (e.g., minority groups), and members who use services inappropriately. If member-relations activities are coordinated by such units as marketing, public relations, or consumer relations, the health education staff can work closely with them.

Member education and organizational change to promote optimal use of services

Materials to help members understand HMO services include newsletters, flyers, bulletins, handbooks, and audiovisuals in languages and formats suitable to the various subgroups within the membership. Open-house and orientation sessions are successful in some communities. Effective programs include combinations of member information, staff training, and appropriate design of operational systems based on systems analyses and consumer input.

In one complex, large HMO, use of orientation brochures combined with training for health care providers and changes in service procedures produced fewer telephone calls that had to be transferred, fewer calls on Monday mornings, and more requests for recommended periodic screening tests in place of annual physical examinations (11). For an urban, low-income population, a family health care program which included nurse counseling, other health education services, and employment assistance resulted in significant and positive changes in utilization of services (12). Many HMOs have still not made adequate telephone advice available to those subscribers who are more apt to use telephone access (13).

Activities and incentives to encourage use of services by high-risk members

Effective measures to improve care for high-risk members include recruitment (and retention) of new clients for appropriate services, such as contraception clinics for adolescents (14), immunizations for children (15), colorectal screening in the elderly (16), and screening of women at elevated risk of breast cancer (17). Special care should be taken to adapt material and approaches for those members who belong to special language or ethnic minority groups. Audits of membership files to identify nonusers or users who "miss" important services such as immunizations should help assure that high-priority preventive services are reaching intended clients (18).

Recruitment, training, and design of feedback mechanisms to increase member participation

Effective consumer participation is encouraged by such organizational commitments as formation of consumer-provider boards and committees, design and implementation of effective feedback and grievance procedures (19), and periodic consumer surveys (20). It is also made possible through developing opportunities for meaningful volunteer work, such as peer counseling (21), outreach workers (15), and making daily telephone calls to check on elderly members who live alone.

Mandated consumer participation in decisionmaking bodies (i.e., one-third subscriber representation on HMO boards) can result in superficial compliance or in meaningful integration of lay and professional decisionmaking and policy development (22). Training and other strategies can often increase the effectiveness of consumer participation (23,24).

Patient and Family Education

Patient education activities can increase adherence to therapeutic regimens. *Given usual care by physicians, at least one-third of patients will reject or deviate significantly from medical recommendations* (25). To decrease this rate of nonadherence, education at each encounter with the clinician should be a standard service, and quality-assessment audits should evaluate adherence to regimen as part of the provider's responsibility (26). A wider variety of program activities must usually be employed to increase adherence significantly. Planned education is also useful to prepare patients for stressful procedures. In addition, risk reduction and routine assistance with developmental adjustments can be improved with educational programs.

Education about medical procedures and therapeutic regimens to improve understanding and adherence

Numerous evaluations of educational programs suggest that adherence can be influenced positively by a variety of providers and methods. Recent findings from a set of 11 randomized clinical trials sponsored by the National Heart, Lung, and Blood Institute (27) show that substantial improvement in blood pressure control can be achieved via educational means. The key to success was followup and reinforcement over time.

An immediate payoff in the form of reduced emergency-room utilization was achieved with group education programs for parents of asthmatic children (28) and for adult asthmatics (29). Another program, which helped adult patients assume responsibility for self-administration of medications while they were still hospitalized, resulted in substantially improved patient adherence to medication regimens and significantly less rehospitalization for the experimental group (30). The use of telephone and postcard reminders of return appointments has been extensively and rigorously evaluated, and has achieved reductions of about 20 percent in broken-appointment rates (31). Home visits to assess environmental factors and enlist family support for therapeutic regimens have also brought success (32).

Education to decrease stress during medical and hospital procedures

Given a combination of systematic preparation, rehearsal, and supportive care before each stressful pediatric procedure, parents and children were significantly less upset and more cooperative than a control group (33). Other successful techniques include the use of modelling through films of other children who are coping with the hospital and surgical setting (34,35,36). Numerous stress reduction studies with adult patients have shown improved psychological adjustment and reduced medication requirements and length of postoperative hospital stay, although the exact psychological mechanisms brought into play are not clear (37). (These study results are summarized in Part 1 of the appendix.) Classes that prepare expectant parents for childbirth have been shown to lead to decreased use of pain medications and a higher rate of spontaneous vaginal deliveries (38,39).

Education and guidance to prevent disease, promote early detection, and facilitate developmental adjustments

It is often easier to deter the adoption of destructive health behavior than to modify well-established practices. Thus, encouraging adequate weight loss after pregnancy and reinforcing nonsmoking among teenaged girls and others at high risk of starting to smoke can be done at low cost. Such efforts appear to be worthwhile, based on studies of school health curriculum projects (40,41). The importance of counseling to promote cognitive and emotional preparation for events, feelings, and alternative responses to events likely to occur is stressed in the recommendations for periodic health services for well populations (7,8,9,10).

The Cooperative Health Education Project, a consortium of the Center for Consumer Health Education, Kaiser-Permanente (San Jose), Prime Health, and Rhode Island Group Health Association, has instituted in two of these HMOs a program of individual and group counseling sessions, clinical algorithms, and newsletters. The outcomes to be measured include health status and utilization of services.

Family planning education for women in the postpartum ward and for women having abortions significantly increased contraceptive use (42,43). Parent education programs on the use of car seats for infants have achieved moderate success (44,45). INA Health Plan of California is evaluating the effectiveness of individualized risk-reduction counseling for high-risk pregnant women covered by Medicaid.

"Health hazard appraisals" or "health risk appraisals" are in use at a number of HMOs and enjoy popularity in worksite and community programs. (These terms are used to refer to the appraisal of risk of mortality or morbidity which systematically relates personal characteristics to epidemiological and actuarial data as the basis for calculating an individual's risk.) Few health risk appraisal programs have been evaluated, although the Arizona program, Well Aware About Health, will have data from a study of different combinations of interventions next year.

Health hazard appraisal is a promising motivational tool which may help an individual decide to enter a readily available program to assist him or her in changing behavior. By itself, however, the appraisal probably accomplishes little. A recently completed state-of-the-art survey and analysis (46) summarized the comments of current users of health hazard appraisals polled during 15 site visits as follows:

> First, the accuracy of HHA [health hazard appraisal] risk projections is not viewed as an important issue but the inclusion of important risk factors is, particularly risk factors related to medical therapy (e.g., estrogens), occupation (e.g., job stress or chemical exposure), or psychological measures (e.g., Type A behavior). Second, programs seemed satisfied with their own HHA...whether it involved the computer or not, whether it used risk ages or a health score, etc. In other words, no single approach to estimating or reporting risk emerged as clearly preferable. Third, many felt that if they had to reduce the scope of their program's activities, HHA would be the first thing to go, reflecting the conviction that it is the specific risk reduction classes and environmental effects, not HHA, which produce behavioral change.

In addition, the investigators concluded that the health hazard appraisal is best used in one-to-one or small group education or counseling. It appears far less appropriate for mass screening programs, because meaningful followup is so often missing in such programs. While the HHA is not a substitute for a physical examination, it is an important tool for organizing the clinician's risk reduction efforts with patients. Interpretation of results to clients is important, particularly in view of the data-base limitations (e.g., problems in estimating risk for ethnic minority groups, limitations of data base for some behaviors). The most appropriate group for HHA consists of educated adults younger between the ages of 30 and 60 years. Guidelines for HHA use are forthcoming from the Society for Prospective Medicine, and inventories of instruments have recently been assembled (46,47).

Member Health Education and Outreach to Community and Worksite

Health education programs are often open to the entire community, and they offer opportunities for the HMO to work with other agencies to meet community needs. Some HMOs are beginning to offer programs at the worksite. Thus, in addition to teaching members about self-care and how to change unhealthy behaviors, outreach and member education programs can meet other HMO needs such as community and market visibility. Some examples follow.

Education to improve management of common, minor ailments

Learning self-care skills and knowledge helps patients with routine or minor problems use professional services wisely. Studies involving middle-class and college-student populations suggest that such programs are acceptable to both members and providers and can be safely conducted at a reasonable cost (48). At the Columbia Medical Plan, for example, parents trained to obtain throat cultures from their children were judged to be as competent as practitioners, did not under- or overutilize services, and decreased contagion of streptococcal throat infections in siblings (49). The Cold Self-Care Center at the University of Massachusetts provides self-screening protocols, information on symptoms and products available for symptomatic relief, and provides patients with the option of selecting their own medications or seeing a practitioner. It has demonstrated substantial cost effectiveness, safety, and both patient and provider satisfaction (50).

Educating parents about first aid and home treatment for minor childhood ailments has led to increased satisfaction on the part of parents and providers and decreased utilization of services (51). Since fever, cough, and ear symptoms are significant predictors of medical care utilization by young families (52), these are important symptoms to target with self-care programs. A pilot program for home care of infant fever at Group Health Cooperative of Puget Sound has shown success in overcoming the tendency for mothers to feel that calling the physician at the first sign of an illness shows that they are more "caring" than those who institute home-care procedures, even when the latter follow a pediatrician's protocol (53,54). Generalized self-care education should not be expected to reduce visits, because many self-care protocols are more conservative than patient decisions (55) and because visits may not be excessive on the average (56).

Education to assist people in adopting healthy behaviors and reducing risk

HMOs have been instrumental in developing effective programs in the areas of smoking cessation, weight control, and exercise promotion (57). While intervention in these areas can be initiated in the clinic setting, the complexity of the issues usually demands multiple and long-term strategies.

Multisession group programs are often used for weight and smoking control. Success rates for smoking cessation are usually 30 percent after 1 year (58,59), although a Kaiser-Permanente program, Northern California, achieved a cessation rate of 47 percent after 1 year (60). Maxicare, a southern California HMO, is experimenting with a smoking cessation program for pregnant women which uses programmed instructional material mailed to participants at regular intervals; a taped telephone call-in device serves as reinforcement.

Weight control classes still attain only modest success in achieving sustained weight loss (61,62,63). New advances have been made in screening out participants who are not ready for behavioral methods. Screening techniques can help assure that prospective clients are indeed motivated to change and are able to use particular educational methods (64). Furthermore, weight reduction classes may be a cost-effective substitute for individual physician visits, as suggested by the results of a study conducted by the Health Insurance Plan of Greater New York several years ago.

Kaiser-Permanente, Santa Teresa (California), has cosponsored a program called "More Effective Living" with local community colleges for the past 6 years. The program features courses on communication in marriage/partnerships, time management, parent-child communication, and assertiveness training. Preliminary evaluation shows a significant decrease in health care utilization by program participants (65).

Media and other public information programs can raise member awareness of particular problems—e.g., lifting or sports injuries and safety hazards—and in general affect the behavior of a small proportion of the audience (66). Habits such as drinking whole milk or eating butter, for which there are acceptable, easily adapted substitutes, are much more susceptible to influence by media (67).

Development of health education and promotion programs to reach contract worksites and HMO employees

The worksite is a fast-growing site for health education and promotion programs, and several evaluations are in progress. Some businesses and industries are establishing an in-house capability; others are purchasing such packages of programs from commercial firms, hospitals, HMOs, and organizations like the YMCA.

The Health Alliance Plan in Michigan was asked by a local corporation to develop a program for its employees, some of whom were already Health Alliance members. The components selected were on cardiopulmonary resuscitation, hypertension screening and followup, and substance abuse inservice training for foremen and supervisors to enable them to detect and manage workers with alcohol-related problems. The HMO's health education department reported favorable health outcomes and felt there would be a marketing advantage for the HMO (68). Mastercare, an Albuquerque IPA, has shifted member education to the worksite, because there is better participation than at central locations during the evenings. Kaiser-Permanente of Portland is testing a health promotion program involving a broad spectrum of its employees in a wide variety of activities. They expect to expand to contract groups at worksites (69).

A series of background papers commissioned for the National Conference on Health Promotion Programs in Occupational Settings, sponsored by the Department of Health and Human Services in January 1979, provides excellent summaries of evaluations and theoretical effects of worksite programs on stress management (70), physical fitness and exercise (71), weight control and nutrition (63), control of alcohol and drug abuse (72), smoking cessation (59), hypertension control (73), and self-protective measures against workplace hazards (74). A guide for health promotion programs will be available this year (75).

Participation with community groups to improve safety and other environmental hazards and to increase health promotion facilities

Collaboration with consumer groups and other local agencies has considerable potential to identify and bring about environmental changes: for example, establishment of community exercise facilities, fluoridation of the local water supply, a law requiring car seats for infants, or the establishment of a stop sign at a dangerous street intersection. The health protection category of the disease prevention/health promotion objectives needs the active support of health care institutions. Two of the institutions involved in such activities are Riverside Hospital in Toledo and Lutheran Medical Center in Brooklyn (76).

Organization Development and Inservice Education

The HMO member is not the only target of education initiatives. HMO decisions related to operational procedures and policies and the actions of providers contribute to an environment which influences and supports health decisions by members. Among these tactics are

Inservice programs and consultation to improve providers' educational skills and sensitivity to other cultures and lifestyles

Numerous studies have demonstrated the significant variation in level of understanding of patients leaving a clinical encounter (77,78,79). More effective interpersonal skills for clinicians can improve this process, particularly in regard to low-income and culturally distinct groups (80,81). Inservice education and consultation on such topics as assessment of individual patients' needs, behavior modification techniques, and communication with difficult patients can improve services and outcomes (82,83).

Design of operational systems to reinforce and improve health education efforts

Operational systems include telephone advice, referral practices, triaging procedures and criteria, and appointment availability and procedures. The importance of such systems in educational efforts has been pointed out in several of the discussions above. Appointment keeping can be improved by systems changes such as individual scheduling rather than block scheduling (31). Continuity of provider, for example, improves adherence to regimen in pediatric care (84). Successful self-care projects often employ procedural changes to allow and encourage greater responsibility by members (30,49,50). A notably cost-effective program for diabetics at a large public hospital combined new procedures with education to achieve over 1 million dollars in savings in 1 year (85). Incorporating explicit goals for individual problem management in the medical record and including deficiencies related to health education in audit procedures have improved patient management (86,87).

Organization development to improve staff satisfaction and working relationships

Health professionals work in increasingly bureaucratic institutions, and this influences staff behavior and morale (88,89). For example, nurses who work in an authoritarian management situation have been found to be much more authoritarian in their orientation to patients than nurses working in a more democratic situation (90). Although organization development approaches are not easily transferrable to medical care settings because the values, rewards, and modus operandi of management and health professionals are quite different (91,92), these approaches can be successful (93,94,95).

Examples of activities of HMOs around the country are presented in table 1 grouped according to the goals, program objectives and strategies discussed in the preceding sections. Suggested minimum professional activity standards based on the literature review may be utilized to guide program development in early stages and to conduct program review. This sets the stage for chapter 2, which focuses on the all-important planning and selection process that pulls together and articulates the component activities into full-fledged programs.

TABLE 1: HEALTH EDUCATION AND PROMOTION GOALS, ACTIVITY EXAMPLES, AND SUGGESTED MINIMUM PROFESSSIONAL ACTIVITY STANDARDS FOR HMOS

GOALS AND PURPOSES	ACTIVITY EXAMPLES	SUGGESTED MINIMUM PROFESSIONAL STANDARDS
1. Promote appropriate use of services and understanding of plan procedures and operations		
To assist members in understanding their benefits and plan operations	Sound/slide tape on HMO and/or individual clinic or group operations New member orientation sessions and tours Enrollee handbooks Flagging of new enrollees' health records to alert staff to explain services and procedures at the first visit Orientation sessions for new staff	Responsibility for public information is clearly designated A vehicle for regular communication with members is established Material explaining benefits, location, hours, grievance procedures, and resources for further information are provided to all new members All new staff are oriented to HMO principles, operations, benefits, and member characteristics
To encourage use of services by high risk members and to decrease inappropriate visits	Newsletters Flyers on special topics: e.g., periodic examination schedule Telephone advice available from nurse consultants	There is a system for monitoring the provision of screening and immunization services to high risk groups Participation of groups at risk in clinical screening and immunization is promoted actively

GOALS AND PURPOSES	ACTIVITY EXAMPLES	SUGGESTED MINIMUM PROFESSIONAL STANDARDS
	Appointment-making and other procedures that facilitate triage and access	Telephone consultation is provided to help members institute home care and/or decide what type of service is needed
	Reminders (postcards and telephone calls)	
	Special mailings, media efforts, and other outreach to achieve early entry into care	
	Special screening programs	
2. Encourage member participation and involvement in advisory, policymaking, and other service roles	Recruitment of consumers for appropriate advisory committees	Planned orientation sessions for consumer leadership are provided
	Training for consumer board and committee members	Appropriate support and information is available to consumer committees
	Staff support for consumer committees	There are opportunities for meaningful volunteer service within the HMO
	Recruitment and training of volunteers to work in service projects	Volunteers are screened and well trained
To clarify member rights and the feedback/grievance process	Establishment and distribution of a **"patient's bill of rights"**	An accessible grievance/complaint process is in place
To determine member needs and perceptions	Periodic surveys of consumer interest and satisfaction	Consumer satisfaction data and suggestions are routinely collected
	Provision of a "hotline" for questions, complaints and problem solving	

TABLE 1: HEALTH EDUCATION AND PROMOTION GOALS, ACTIVITY EXAMPLES, AND SUGGESTED MINIMUM PROFESSSIONAL ACTIVITY STANDARDS FOR HMOS (cont.)

GOALS AND PURPOSES	ACTIVITY EXAMPLES	SUGGESTED MINIMUM PROFESSIONAL STANDARDS
3. Improve members' participation in the clinical process		
To enable patients and/or their families to manage common minor health concerns	Weight management workshops Self-care center for colds Community discussions on emergency care skills, common childhood illnesses Self-care algorithms	Practical and specific self-care materials covering common problems are offered
To encourage self-monitoring for early warning signs	Pamphlets, demonstrations, and guided practice of breast and testicular self-examination procedures Guides for parents to observe developmental, hearing, vision, and other problems in children Self-care algorithms	Demonstrations and advice about appropriate self-screening procedures are given during periodic examinations or at other visits for high risk members
To help patients manage long term illness and to promote adherence to prescribed regimens	Special group sessions e.g., parents of asthmatic children, diabetics, post-MI, lower back pain, and COPD patients	Patients (and families when appropriate) are educated about their diagnosis and regimens and are taught necessary skills for the regimen

GOALS AND PURPOSES	ACTIVITY EXAMPLES	SUGGESTED MINIMUM PROFESSIONAL STANDARDS
	Establishment of referral system for educational programs (e.g., "educational prescription")	Patient education at each visit is noted in the medical record and includes specific objectives
	Individual patient and family education	
	Provision of information sheets, drug package inserts and drug reminder forms	Educational criteria are part of quality assessments whenever appropriate
To decrease stress during medical and hospital procedures and to achieve informed consent for therapeutic procedures	Special staff protocols, e.g., for preoperative education	Preparation for surgery and other stressful procedures includes appropriate information and guidance
	Prepared childbirth classes	
	Pamphlets, fact sheets, on x-ray and laboratory procedures	
4. Reduce behavioral risk and promote health and well-being		
To promote healthy behaviors	Sponsorship of lifestyle improvement seminars, e.g., jogging and fitness clinics and nutrition and smoking cessation groups	At periodic health examination visits guidance and counseling are given on risky behaviors
	Lecture series/community forums: e.g., "Holiday Stress," "Self Care for the Family," "Communicating with Your Child About Sex," preventive dentistry	Information on recommended health practices is provided to supplement other educational methods such as physician/nurse counseling

CHARACTERISTICS OF SYSTEMATICALLY DEVELOPED PROGRAMS

Based on Sound Data	*Versus*	Casual Impressions
Behavioral Science	*Versus*	Hunches
Measurable Results	*Versus*	Focus on Activities
Sustained Effort	*Versus*	Short Term Campaigns
Systematic Approaches	*Versus*	Piecemeal Activities
Targeted Coverage	*Versus*	Hit or Miss Coverage
Member-Provider Partnership	*Versus*	Provider Perspective

CHAPTER 2

PROGRAM DEVELOPMENT

The development of an overall health education and promotion plan requires systematic assessment of program needs from consumer, staff, and organizational perspectives; determination of priorities from among these needs; and the formulation of programs based on finer diagnoses of specific problems. Program development in an HMO involves three organizational levels:

- the *organization-wide or systems level,*
  which encompasses the entire organization and the community;
- the *programmatic level,*
  which differentiates specific groups of members by disease, by demographic and linguistic, and cultural characteristics, or by facility; and
- the face-to-face, *individual patient level*
  which considers direct, personal interaction (2).

Each level of the planning process is associated with different participants. At the organizational level the key participants are the top level decisionmakers, namely the board of trustees, the medical director, and the administrators. At the programmatic level they are likely to be the chiefs of services and unit supervisors. At the patient care level they are direct service providers and patients and their families.

In this discussion of needs assessment, priority setting, and planning and selection of intervention approaches, we will focus on the organization-wide and programmatic levels. With the development of the more generalized levels, individual education is likely to be both easier and more effective.

Assessing Needs

Just as diagnosis is the basis of a medical treatment plan, needs assessment or diagnosis is essential to educational planning. The needs assessment stage identifies those areas of behavior *where benefits are attainable but have not been realized.* These are health benefits primarily, although benefits to the organization—member satisfaction and appropriate use of staff—should also be considered.

Many sources of information can be used for a needs assessment: State and local health and risk factor data; feasibility study data; operations data; systems analyses; information from consumer surveys, provider surveys, and advisory groups; and community resource data. Results are likely to vary, depending upon the biases inherent in the method used. More objective methods, such as population-based assessments of risk and health problems, are best for obtaining assessments of health and behavior problems. Subjective methods may be less costly and supply important information about priorities which may indicate readiness to participate in a program and any preferences for educational methods. The experience of Genessee Valley Group Health Association in one needs assessment cycle illustrates the differences in priorities among different groups. Their physicians rated member education, self-care, and smoking most highly, while randomly selected members ranked hypertension, child abuse, and obesity most highly. Obesity, member education, and hypertension were selected as areas of priority by the board of directors; a consumer advisory group felt that stress, child abuse, and smoking were the areas of greatest concern (96). It is important, therefore, to use multiple techniques and sources and to reconcile differences on a rational, negotiated basis.

- **Data From State and Local Agencies**
  Data from State, regional, and other agencies can be used to supplement HMO sources. For example, most States now have risk reduction programs located within the State health agency, and these programs gather information about risk factors such as smoking, obesity, and exercise habits among population groups within the State. Application of the risk prevalence data to the HMO population, using breakdowns by sex, age, ethnic group, and other significant demographic variables to adjust for HMO and State population differences would help estimate risk prevalence for the HMO membership. Unfortunately, in the case of certain ethnic minority groups, such as Hispanics, regional data may not be complete. Local health departments have information about communicable diseases, immunization rates, maternal and infant morbidity and mortality, and general mortality information, including data on accidents. Tumor registries, poison control centers, voluntary agencies, and local colleges and universities are other sources.

- **Feasibility Study Data**
  Much can be learned from such demographic information as family composition, geographic distribution, and cultural and ethnic

characteristics. For example, a large number of women of childbearing age indicates a need for prenatal education services, and if the women are predominately from low-income groups, recruitment for early prenatal care and more intensive counseling to reduce high-risk behaviors should be planned. A population widely distributed geographically may need to have educational services available at the same time as a clinic visit and/or decentralized and provided in conjunction with other community members so that groups can be formed.

- **Operations Data**
  Various management information systems provide data on utilization by type of provider, site, purpose, initiator of the encounter, and hospital admission rates by disease and demographic grouping (e.g., Professional Activity Study-Medical Audit Program data [PAS-MAP]), obstetrical and surgical logs, quality assurance audits, kept-appointment rates, and telephone-call logs. Utilization data need to be supplemented with assessments about the timeliness of care seeking and relationship of numbers and types of utilizers to the total population in need of the service. The latter is often difficult to obtain without sampling medical records of, e.g., children to ascertain immunization rates or middle-aged black men to find the numbers who have received medical care within several years and who have been screened for high blood pressure. Periodic samples of telephone logs are well worth keeping, since telephone consultation consumes large amounts of time and is an increasingly important method of triaging and advising on member problems. Finally, grievance and disenrollment records provide insight into systems and general personnel problems.

- **Systems Analyses**
  Analyses of patient flow, telephone call transfers, unfilled prescriptions, and new member enrollment and orientation procedures can yield valuable information on problem areas which indicate system design flaws or misunderstandings on the part of members and/or staff. Do members submit inappropriate out-of-area claims? Do clinicians provide incorrect information for specialist referrals? Do patients with specific problems make telephone calls at predictable times and ask predictable questions? For example, charting the questions most frequently asked by new parents may lead to producing materials which anticipate these questions or even to conducting cluster appointments with group education sessions.

- **Provider Surveys and Advisory Groups**
  In an operating HMO, formal and informal interviews and written surveys of staff can help identify patient and staff needs as well as operational issues which would benefit from educational interventions. For example, receptionists and nursing staff can usually cite the areas of confusion and misunderstanding often remaining after a patient's visit with a clinician or pharmacist. Clinicians may identify misunderstandings about HMO procedures which lead to tension with their patients. In addition, plan marketing staff may have information about the interests of contract negotiators in preventive and educational services. (The appendix contains examples of staff surveys.)

- **Consumer Surveys and Advisory Groups**
  Consumers should participate in identifying health education and promotion needs. Board members and special councils such as that established by the Columbia Medical Plan can contribute significantly to organization-wide planning. (The charge to their advisory committee at Rhode Island Group Health Association appears in the appendix.) Advisory committees can be organized to help plan specific programs. Simple surveys and postencounter assessment forms can be used effectively to gauge interest. More formally developed opinion surveys can provide information about member health practices, their views on their own and the community's health needs, their knowledge and use of available health care services, their expectations of the HMO, and the nature and extent of their interest in learning how to improve and protect their own health. (The appendix gives examples of consumer surveys.)

When designing provider or consumer surveys it is important to provide direction to shape the categories of responses, since the lists are otherwise likely to be an admixture of health status outcomes (e.g., high incidence of early coronary death, sequelae of uncontrolled hypertension, and low birth weight), behaviors (e.g., smoking, high broken-appointment rates, and numerous drop-in visits for simple colds), and knowledge and attitudes (e.g., knowledge about basic nutrition and staff attitudes toward patients). One practical approach is to set up a three-column list to include in column 1 health status, utilization, well-being, and other outcomes; column 2, the contributing behaviors; and column 3, the knowledge and attitudes of staff, members, and families. Respondents may not be able to fill in all three columns, but this may help them reason through the ultimate benefit and contributing causes of their identified problems. When such a complex listing is impractical, the category of choice is usually the behaviors.

Few HMOs and no communities are without existing education and promotion activities and programs. Also, many health education units are organized after the HMO and/or its component groups are well established. Therefore, two other types of inventories should be taken:

- **Inventories of Ongoing Programs and Activities in the HMO**
  Group interviews with clinic or office staff, interviews with key managers and supervisors, and perusal of activity reports can all be used to ascertain the type and extent of education and promotion programs. The appendix contains two interview schedules used in a recent inventory conducted in a large group model plan (97). One suggested classification divides activities from more sustained and intensive programs.

Activities	Aimed at achieving intermediate learning objectives (such as increasing knowledge) which are assumed to predispose a consumer or patient to adopt a behavior, e.g., mass media messages. They are often single interventions, not necessarily sustained over time.
Programs	Combinations of interventions designed to influence behavior. They typically coordinate a series of contacts with consumers or patients.
Intra-Mural Services	Assistance to personnel who are conducting teaching and instructional sessions with consultation and/or materials (98).

- **Inventories of Community Resources**
  Many communities have a rich array of services offered by local health departments, schools, colleges and universities, community mental health centers, cooperative extension agencies, community service organizations, and voluntary health agencies, among others. Continuing inventories of existing health education and promotion resources are kept by risk reduction programs in State health departments. Community services directories also provide information to help an HMO decide which services should be offered inhouse or by some shared arrangement and which by referral. An inventory also can serve as a useful referral guide for staff.

During the assessment process, a wide variety of needs or problems may be listed: frequent use of the emergency room by persons with particular chronic conditions (e.g., asthma), a high incidence of low-birth-weight infants, poor health habits among middle-aged populations, use of clinician time for repetitious education that could be handled as effectively or even more effectively in group programs, high rates of unhealthy practices among members at risk for illness or trauma, perceptions among members that the HMO is not interested in prevention or in providing high-priority psychosocial or educational services, or lack of visibility for the HMO in the community.

Setting Organizational Priorities

Given one or more lists of needs and preferences, how should priorities be set? Entries will vary with regard to several characteristics, including type and extent of the impact on the HMO and its members, probable effectiveness of any current interventions, and the immediacy of the benefit of additional interventions. In addition, there is a general context to consider, arising out of the organization's stage of development, market position, and interest in programs to reduce long term health risks as opposed to immediate payoff. The new HMO may be seeking high visibility and immediate lowering of risk of rehospitalization for chronically ill members with particular diagnoses such as diabetes. Well-established IPAs may be seeking more efficient modes of patient education and health habit modification to reduce this burden on physician time and use other HMO resources. The health education and promotion unit will likewise have its own limitations, strengths, and needs resulting from its developmental stage, degree of acceptance within the organization, and resources. New units or coordinators may need to start with short term activities requiring less planning time. Better established units will be able to orchestrate complex programs which may involve organization development and staff training.*

Thus, varying criteria will be used to establish priorities to conserve and concentrate educational resources on those areas of greatest impact and to avoid the tendency to invest in activities or programs that will not lead to substantial benefits. The epidemiology and medical care literature, and staff, member, and administrative experience and opinion will help determine the benefits of such changes. The important point here is that relationship to tangible outcomes is scrutinized, and basic priorities are set into an agreed-upon plan over a 2- to 3-year period (11,97). This plan should contain a listing of goals in rough order of priority, and these goals should be selected for their *value* and their *achievability*. Achievability depends on two variables: 1) the relationship of individual or group behavior to the goal and 2) the effectiveness of educational methods in influencing the relevant behaviors.

It is important, therefore, first to confirm that any specific behaviors which have been named or which are the subject of an existing program are indeed significantly related to the problem. Working backward from the desired outcome—health status, utilization rate,

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*For longer discussion of the stages of development of a health education unit, the reader is referred to Deeds, S.G., Vosen, B. Developmental stages of health education in HMOs. *Health Education Quarterly* 8: (In Press), 1981.

member satisfaction level—as in the construction of a Program Evaluation and Review Technique (PERT) chart (99), identify the likely causal behavior or behaviors and other factors. For example, high rates of rehospitalization for diabetes may be affected by patient adherence to prescribed regimens, clinician prescribing practices, or emergency room management of diabetic crises. Environmental, biological, and medical care factors should be considered along with behavioral factors in attributing the cause or causes of a health problem. Systems factors should be considered in addition to member behavior when assigning the cause of a utilization problem. For example, when one large HMO investigated the reason women waited until the second trimester to receive prenatal care, it was discovered that the appointment system itself prevented even the most diligent woman from being seen earlier.

Next comes consideration of the probable effectiveness of educational intervention in the problemmatic behaviors. Unfortunately, at present our effectiveness in achieving reduction in smoking or an increase in use of seat belts is not the same. Achievement of some changes in behavior or even in health status may not result in a shift in utilization.

Figure 1 charts several popular health education and promotion activities and gives examples of benefits and achievability criteria. Quadrant I contains activities shown to be effective in achieving specific changes in behavior. However, because the problems they address are too distant, infrequent, or inconsequential, these programs may not considered cost effective in terms of health benefits. The program options in Quadrant II should be examined to determine the extent to which achievable benefits are currently being realized. Such programs—with high effectiveness and high benefit to the members and to the HMO—are obvious candidates for priority and should be scrutinized for organizational as well as demographic fit. Quadrant III lists examples of activities with relatively low effectiveness and low or dubious health benefits. Quadrant IV lists programs with low effectiveness, but which can reap significant health benefits when impact is positive.

Care must be exercised in using this table, as implied by the footnotes. Data on such practices as breast self-examination are not definitive. An asthma education program for frequent emergency-room users would have strong prospects of improved management and comfort for patients and families and short term payoffs in reduced ER visits. It, therefore, might be a more pressing priority than education for a chronic illness with fewer or more easily managed crises. Smoking cessation is linked to health benefits, including short term effects in the case of pregnant women and effects over a much longer period in the case of teenagers. However, the HMO with many concerned parents of teenagers might want to elevate adolescent smoking to a higher priority.

TABLE 1: HEALTH EDUCATION AND PROMOTION GOALS, ACTIVITY EXAMPLES, AND SUGGESTED MINIMUM PROFESSSIONAL ACTIVITY STANDARDS FOR HMOS (cont.)

GOALS AND PURPOSES	ACTIVITY EXAMPLES	SUGGESTED MINIMUM PROFESSIONAL STANDARDS
		Assessment of the prevalence of risk behaviors in the enrollee population is undertaken periodically
		Some assessment of lifestyle habits for individuals/families is offered
To contribute to developmental adjustments	Parenting groups, retirement groups, child safety restraint publicity, car seat loan programs, Ipecac and poison safety information, and home accident prevention media campaigns and counseling	Prenatal and pediatric care include counseling about important health habits such as smoking and infant car seat use
5. Improve HMO capability to do effective health education and promotion		
To promote education and communication skills of clinical staff	Staff seminars on aspects of minority cultures and lifestyles which influence behavior and expectations, patient-staff communication	Staff training and appropriate systems changes to ensure professional reinforcement and promotion of patient behavior is provided
	Staff training on educational diagnosis and intervention	Specific educational responsibilities are delineated in job descriptions of all professional staff who give patient care

Figure 1*

ACTIVITY EXAMPLES: HEALTH BENEFITS AND EFFECTIVENESS

BENEFITS

		Low	High
EFFECTIVENESS	High	Mass screening on rare conditions or on those for which there is no ameliorating action (100) Sexuality programs[a] Parenting workshops[a] Retirement workshops[a] I	Smoking cessation programs (59,60,101) Self-care for specific symptoms and ailments (51,102) Patient education groups—diabetes (85), asthma (28), and lower back pain (103) Presurgical education (37) CPR training of staff and selected members, e.g., myocardial infarction - family members Mailed reminders or telephone calls to decrease no shows (31) Improving clinicians' educational skills (82,83) Prepared childbirth classes (38,39) Contraceptive education, BSE instruction with guided practice (104)[b] II
	Low	Provision of general self-care manuals for adults (55)[c,d] Weight reduction classes[c] CPR skill development of members[c] Breast self-exam instruction without guided practice (104) III	Adult seat belt use education (66)[d,f] Alcohol abuse education[d,f] Mass media efforts to influence complex lifestyle behaviors (67)[c,d] "One-shot" programs for hypertension management (27) or other complex regimens IV

*See Explanation of Codes on facing page

Figure 1. ACTIVITY EXAMPLES (Continued)

Explanation of codes:

[a] May have important, nonhealth benefits, e.g., contribution to quality of life

[b] Data and research not definitive

[c] Have high public appeal and visibility and increase awareness or reinforce existing motivation

[d] Low effectiveness must be weighed against low cost per successful case

[e] May be more effective than traditional modalities such as individual counseling

[f] Doing "something" in regard to a highly prevalent, risky behavior may be worthwhile

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Moderate obesity is much less strongly linked with either long or short term outcomes, but certain types of interventions such as classes may be cost-effective alternatives to individual clinician counseling. Weight reduction programs are also popular with members. Thus, on other grounds, such as substitution effects and member relations, moderate obesity might be given higher priority than it would solely on the basis of its contribution to health benefits. A public lecture series on fitness, sports medicine, or on parenting and the health problems of infants and toddlers, or safety seminars offered to all interested employees of local companies where the HMO would like to establish contracts or increase its penetration may be viewed as giving a valuable boost to visibility for the new HMO or the HMO experiencing new competition. CPR training does not improve health, unless a critical mass of citizens have the skill (as in the city of Seattle, where the mortality rate for cardiac arrest declined as more citizens became proficient in CPR). However, it may have high public appeal and visibility and make a contribution to overall community health.

The potential benefits and effectiveness of the health education activity or program must also be weighed against the intensity of effort and expenditure of resources required. For example, mass media efforts alone will not usually bring about change in behavior, but they help create awareness and reinforce existing tendencies. An article in an HMO newsletter about back-strengthening exercises may cause only a few people with low back pain or weak backs to exercise, but the value of the article in terms of public awareness and encouraging people to continue exercises already prescribed may compare favorably with the cost per successful outcome obtained through a group program. On the other hand, a low back pain group may be a high priority, depending on physical therapy and orthopedic referral data. When the behavior is a high priority in terms of health benefit—e.g., recruiting pregnant teenagers for prenatal care in their first trimester—

outreach counseling or other more costly or intensive interventions would be justified.

In summary, priorities should be selected on the basis of the relationship of a behavior to outcomes of value to the HMO, the potential for change, the cost/benefit ratio of the educational effort required to bring about the change, and the readiness within the organization to initiate and support the program.

Designing a Program*

For problems assigned high priority, objectives should be formulated—a statement of the desired outcome indicating who is to do what and by when (105). (A set of objectives for a health education department for one year is contained in the appendix.) A more refined analysis should then be conducted—one which identifies the causes of the behavior so that appropriate interventions can be selected. One such analysis uses three categories of influencing factors:

1) *Predisposing factors* are those social and psychological forces that motivate an individual or a group to take or not take a health action. A hypertensive patient may not follow the regimen because of a belief that he or she is really not sick; 2) *Enabling factors* refer to the availability and accessibility of specific resources or skills necessary to initiate appropriate action. A referral mechanism may be too complex, in which case the mechanism itself, not the member, needs to be changed; 3) *Reinforcing factors* refer to health professionals, friends, family members, or other significant people who reward (or punish) certain attitudes, values, and behaviors. The pharmacist may fail to reinforce directions of a prescribed regimen, or may even offer dissonant information (3).

This process improves the specification of the problems to be addressed by the educational program. Is it that people simply do not know about health consequences of an action? This was true with regard to pregnant women and smoking several years ago when the link was not yet certain. Lack of knowledge sometimes contributes to nonadherence to regimens. For some people, information alone in an acceptable form is enough to influence behavior. However, there may be beliefs and attitudes which countervail against the facts. A patient's bias against taking drugs when he or she is not feeling ill may interfere with completing a full course of antibiotics. Beliefs about susceptibility to a particular health problem and about the efficacy of a preventive action will influence the taking of that action.

Enabling and reinforcing factors merit much more emphasis. Any motivations stimulated by a health risk appraisal, for example, may

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*For a discussion of planning steps for specific member education topics, the reader is referred to U.S. Department of Health, Education, and Welfare. *A Guide to Health Education in Ambulatory Care Settings*. Reference 1.

not be acted upon because of lack of skills or resources, or the securing of these resources may require unusual commitment. Thus, infant car seat loan programs, free bottles of ipecac, or fever thermometers may be important to provide for some groups; evening or Saturday clinic hours may be necessary for others. Reinforcing factors are of special importance to the long term changes which are sought in relationship to regimens for chronic illnesses and habits of daily living. The patient may want to follow his or her regimen and feel able to do so, but this interest may diminish in the face of family indifference or ridicule. In such situations booster sessions, followup telephone calls or post cards, meetings with family members, and/or provision of printed material such as drug reminder forms and instructions are among the techniques which may be employed. Many clinicians need continuing or inservice education about their role in helping patients maintain a new behavior.

The selection of intervention techniques should be guided by this analysis and by appropriateness of the techniques to the resources and operations of the HMO. Ideally, the principle of using combinations of techniques which address at least two of the three categories of factors, will strengthen the program. Further guidance for such selections can be found (2,3,106). The appendix provides examples of educational protocols.

To review, program development includes setting priorities among problem behaviors, specifying objectives, analyzing causal factors, and selecting appropriate techniques.

This section has only touched upon the crucial involvement of members and staff in the planning process and the need for sufficient resources to embark on systematic planning. Many a promising start has foundered because of insufficient funding, poor placement of the health education and promotion unit within the organization, and lack of support and cooperation. The organizational arrangements that make such planning possible are described in chapter 3.

ADMINISTRATIVE POLICIES FOR HEALTH EDUCATION AND PROMOTION

- Organization as a separate, identifiable function with a separate budget

- Location of the health education and promotion unit at an organizational level which provides for direct communication with all departments

- Clear delineation of the relationship of the unit to other departments

- Active support by high-level administrators and medical staff for the health education and promotion unit and for the related functions of other staff

- Coordination of the health education and promotion program by a trained and experienced person

- Appointment of the health education director as early as possible in the development of the HMO

- Delineation of the health education responsibilities of other staff members in their position descriptions

- Written policies and plans for health education, including purpose, scope of activity, objectives, staffing, and quality assurance

- Allocation of adequate personnel, facilities, and fiscal resources for the plan to be carried out

CHAPTER 3

ADMINISTRATIVE ISSUES

A high-quality health education and promotion program involves almost all components of an HMO. Achievement of the program's goals may depend on thoughtful review of such general administrative considerations as program expectations, the need for managerial support, organizational placement, and staffing. This discussion draws on administrative principles and the organizational realities of health care settings (88,92,106,107,108,109).

Expectations

While positive health behaviors can be affected by appropriate health education strategies, the new emphasis on health promotion and health education sometimes leads to overly optimistic expectations of program effectiveness. The behaviors in question are often habitual and deeply ingrained and are not susceptible to lasting change without sustained, personalized approaches. Sometimes what is perceived as a problem with consumer behavior (e.g., "overutilization") may be much less extensive than believed or may be caused by deficiencies in organizational systems. Also, a program's impact may be modest in comparison to an absolute standard of 100 percent, but much more impressive relative to other options with respect to effectiveness and/or cost.

Overly optimistic expectations frequently include not only the amount of change but also its speed. Change often comes slowly. This applies to program development as well as to individual behavior. The pressure to produce rather than plan usually leads to the premature production or purchase of publications and audiovisual materials. It is important to allow time for the educational diagnosis and program development process outlined in chapter 1. For example, 9-12 months would not be an unreasonable period for the development of a patient education program. Such programs may require considerable committee work with health care professionals to gain consensus on the content of materials or topics to be covered in group sessions. Inservice training for providers is usually needed before a specific program can be put into operation. Thus, specific objectives for a health education and promotion unit should be negotiated annually, with opportunity for revision if necessary resources or cooperation are not forthcoming on schedule. (See the appendix for the annual objectives for an established department.)

Cost effectiveness is an important consideration and has already been demonstrated for programs in some behavioral areas. (See chapter 1.) However, the pressure on health education programs to show cost effectiveness is often disproportional to that placed on other services, particularly traditional clinical activities, and to the amount of resources allocated for the program. Much can be gained by the redirection of existing resources; ineffective education is already costing something, whether in the wasted time of highly paid personnel or in poor adherence to expensive regimens.

Support and Sponsorship

Planning and coordinating across disciplines is difficult in the health field, particularly in a new service area. Past experience has shown that without ongoing, active support of decisionmakers, the health education staff will often be able to do little more than disseminate information and, perhaps, conduct isolated educational groups not necessarily relevant to the priority problems of the HMO. Therefore, the HMO's executive director, site administrators, and medical director need to provide resources and strong backing for the health education and promotion unit and to clarify their expectations for it (93). To overcome professional territoriality and the tension caused by a sometimes unfamiliar perspective, medical staff, other professional groups, and managers need to give a consistent and strong message that health education and promotion are highly valued and that cooperation is expected. This is crucial to the resolution of tensions arising from such issues as professional territoriality and the health educator's need to focus on the consumer's perspective.

The health education and promotion director's role may not be well known to other staff members. Physicians and other clinicians may need to be assured that their advice to individual patients will not be subverted; nurses may also need assurance that their teaching role will not be threatened (94). Because HMOs are cost conscious, other staff may feel that a less traditional program is taking resources which would otherwise belong to them. One form of support an administrator or medical director could offer is resources for a regular newsletter for staff from the health educator to alert them to new education and promotion services. This will create awareness of the practical utility of having such a professional in the HMO. (The appendix gives an example of one newsletter for physicians.) In another vein, the support may have to be in written form, e.g., in job descriptions and agreements with IPA groups.

Several health disciplines may have educational responsibilities in a comprehensive program. Although many health education and promotion activities are initiated and in large part delivered by clinicians who also provide medical input to the development of policies, procedures, and content, important roles are also played by other staff. These include the receptionist, clinical aides, and others who have direct contact with members. Such staff members may need more formal educational training and responsibilities.

Because their activity is designed to promote consistency and coordination within the HMO system and because they emphasize the consumer viewpoint, health education staff members sometimes identify organizational problems. This may promote uneasiness and may even be viewed as instigating trouble or making work for others. An astute and supportive administration will see this as a positive contribution to the development of an effective system.

Organizational Placement

The health education unit or function should be located high enough in the organization to be able to foster interdisciplinary coordination. Naturally, the specific placement will depend on the structure and size of the organization. One effective model is for the health education director to report within the medical staff as a chief of service (e.g., Genessee Valley, Kaiser-Permanente Santa Theresa). Under another model, the health education director is head of a centralized department within management (e.g., Group Health Cooperative of Puget Sound, INA Health Plan of California).

Variations in organizational placement reflect the complexity of the HMO. For instance, a health education director might function as a director of decentralized services and give overall policy direction for the organization and technical support to health educators in separate facilities who report to the facility manager (e.g., Kaiser-Permanente of Northern and Southern California). Many IPAs are geographically diffuse, with relatively few prepaid patients at a given site. The only centralized services are the basic managerial and accounting systems, with few, if any, centralized professional services or policies. Yet, it would probably be efficient to have a single service for ordering materials and for training and consultation with office staff.

Organizational placement should allow relatively direct access to the chief executive officer and the medical director, and should entail membership on middle management or chiefs-of-service teams. Ideally, the person responsible for program quality has line authority over program personnel, either as the sole supervisor or in a matrix management arrangement (107).

The responsibilities assigned to the health education unit are a matter of individual organizational preference. Duties such as organization development, inservice education, marketing, member relations and publications, and health education and promotion may be assigned singly or in combination to such a unit. These are complementary responsibilities, and they need to be coordinated. If they are to be combined, and in a small HMO this may be economical, health education and promotion goals and functions should be explicit and not be overshadowed. It is important to assure appropriate staffing for each area and to maintain separate budget allocations.

To help develop strong educational programs and provide a central resource, the health education staff can benefit by working with a representative, organization-wide committee charged with recommending program policies, priorities, and procedures in health education. If consumers do not sit on this committee, a separate advisory committee should be established.

Staffing

It is desirable for a newly developing HMO to hire a qualified person to direct the health education and promotion program as early as possible. Educational theory and methodology represent an identifiable discipline, and hiring a specialist will help insure high-quality programs. If responsibilities are clearly designated, program efforts are more likely to be properly documented and communicated to all sites and departments; unnecessary duplication of effort can be avoided; clinicians will be supported by a balanced and useful array of resources and expertise; and existing community resources can be tapped more effectively.

When health education and promotion directors are hired in well-established HMOs, the initial inventories typically reveal a wide array of activities. These activities are, however, not necessarily directed toward the major problems of the HMO membership, are often duplicative, fragmented and unsustained, and usually depend on the interest and energy of a single staff member. Staff members may not be familiar with health education and promotion literature or with state-of-the-art programs. Unfortunately, in large HMOs staff members frequently are not aware of one another's interests and activities. Thus, ineffective activities burgeon and effective ideas are not widely implemented.

Functions

The health education director may have several functions (111), depending upon the HMO's stage of development, resources, and total configuration of professional skills, but their overall function is that of a manager.

- **Coordinator and planner**
  The chief duties of the health educator are to improve consistency and continuity for consumers and to address the multiple factors which affect health behaviors—the member, the provider, and the operational system within which they function. HMO education extends far beyond a practitioner's office, e.g., to a prenatal education group, to the marketing program, and to grievance procedures. By looking at the implicit and explicit messages and procedures in operation, a health educator can help keep contradictions to a minimum, close information gaps, and create a workable flow of communications among providers and consumers.

- **Consultant and trainer**
  As other staff members become more interested in improving their health education efforts, this function grows in importance. For example, a pediatrician might want to work with parents of asthmatic children. A health educator could assist with the selection or design of educational materials, suggest ideas such as group visits, a parents' workshop, or referral to existing community resources. Health educators can conduct training for support staff on such topics as dealing with angry patients or more effective techniques for giving advice over the telephone. The health educator can help design patient flow and other systems to assure compatibility with patient needs and preferences.

- **Direct service provider**
  Health educators may lead educational groups and provide individual consultation and health information through audiovisuals. However, such functions should not be allowed to overshadow planning and coordination. The health education director can often accomplish more by developing a program and training others, such as ex-smokers, to be group leaders.

- **Ombudsperson**
  The health educator can assist the HMO and staff in self-appraisal and in dealing with the tension which sometimes arises between provider and consumer interests. The health education director is also in a position to advocate change in the larger community by contributing to the clarification of health problems and assisting with the mobilization of community resources.

The relative importance of these functions will vary according to the organizational context. For example, in the IPA, greater emphasis may be needed on audiovisual materials, staff consultation and training, and arranging cooperative programs with community agencies. Different combinations of functions are represented in sample position descriptions in the appendix.

Qualifications

Sound management dictates that a qualified person—the director—coordinate the myriad of health education and promotion activities within the HMO. The director then is held accountable for planning and quality assurance. If no one is held clearly accountable, everyone's responsibility too often becomes no one's responsibility. Fragmented efforts are less cost effective (108).

The specific qualifications of a director are

- Technical knowledge of and ability to apply interpersonal communications, group process, and community organization principles, and educational and systems technology to service activities;
- Sound knowledge of and ability to apply educational and social science theory to behavior change strategies;
- Knowledge about health, disease, and the delivery of medical care, including understanding of the principles of public health, epidemiology, and biostatistics;
- Management skills, including the ability to plan, organize, and monitor specific activities;
- Creativity and a high degree of competence in written and oral communications;
- Understanding of the roles of various health professionals and their interactions and demonstrated ability to work effectively with such professionals;
- Understanding of consumer needs and their relationship to the health care delivery system, and demonstrated ability to work effectively with consumers.

Candidates for director who possess these qualifications are most likely to have had the following training and experience:

1. Master's degree in public health education or equivalent, with a minimum of 3 years of experience in planning and implementing health education and health promotion programs;
2. Master's degree in a related field (nursing, social work, behavioral or health sciences, health administration, education), with at least 3 years of experience in planning and implementing health education and promotion programs. Continuing education in health education is also necessary;
3. Bachelor's degree in health education, with a minimum of 4 years of health education experience including administrative/managerial experience;
4. Bachelor's degree in a related field (nursing, social work, behavioral or health sciences, health administration, education), with a minimum of 4 years of health education experience including administrative/managerial experience supplemented by continuing education in health education; or

5. Five years of progressively responsible experience in health education and health promotion programs supplemented by continuing education in health education.

Other professional staff in the health education and promotion unit should be competent in educational methodology and may need special expertise in nutrition, physical conditioning, or prenatal and parenting education. Depending upon the characteristics of the HMO membership, some staff might need to be bicultural or bilingual.

Although there is not yet a licensing or certification process for health education specialists, announcements of positions in the established community health journals, communication with education units in other HMOs, and contact with community health education graduate programs should prove helpful.

Staffing Ratios and Patterns

The staff members needed in addition to the director are determined by the type of HMO, number of sites, stage of development, size, member characteristics, functions of the health education and promotion unit, and scope of health education and promotion activities within the benefit package. No staffing ratios for health education specialists have been established as yet, primarily because of these variables. However, general guidance can be derived from the HMO examples in table 2. (These ratios do not include necessary support staff nor hours contributed by other professionals not charged to the health education and promotion budget.) For smaller plans, one full-time equivalent (FTE) professional per 10,000 members up to 20,000 can achieve moderately paced development of programs in all five functional areas listed in tables 1 and 2. Such a ratio is higher than the IPA example in table 2 where member relations, orientation to the plan, and member participation are handled by another unit and where packaged patient education and health promotion programs were used to get activities under way. It is a lower ratio than Multi-Group Health Plan's, where a portion of the development grant was allocated to establish rapidly a range of activities in all five functional areas.

Valley Health Plan has made health education a capitated benefit. Their ratio of 1:4100 enables the plan to provide extensive services in all functional areas. Other smaller, developing plans limit their activities initially and hire a specialist on a part-time basis or one who can perform additional duties. Very small HMOs might make a larger initial investment to cover many diverse service sites and then later depend on other staff to participate in educational activities without hiring additional education specialists.

The mid-sized plans (Genesee Valley Group Health Association and Rhode Island Group Health Association) shown in table 2 have ratios of 1:35,000 and 1:14,500, respectively. Genesee Valley's marketing staff has responsibility for orientation to the use of services, and nurse coordinators paid from other budgets and cost centers coordinate some of the programs.

For larger plans, the staff-member ratio is usually lower, reflecting the economies of scale that can be achieved because the functions of a health education and promotion unit are principally planning, organizing, training, and consulting and only in part, providing direct services. Thus, Kaiser-Permanente Medical Care Program of Northern California and Group Health Cooperative of Puget Sound, the two large HMOs in the table, have lower ratios (1:52,000 and 1:30,000, respectively). Group Health Cooperative's staff has remained the same size since the membership numbered 235,000.

With a core staff in place, several options to hiring additional staff can also be considered.

- **Contracting for selected services with existing community resources**
  If a particular service in the benefit package is being offered by an existing group or agency in the community, the HMO might contract with that group to provide services to enrollees. This is recommended in cases where the service is structured and the HMO can review professional standards periodically, and where referrals can be effectively managed. Such arrangements may be useful for specialized services or specialized population groups, e.g., adolescent mothers, non-English- speaking persons, or patients with rare diseases. For example, one small, semirural HMO, the Valley Health Plan, contracts with an outside organization for childbirth preparation classes because the HMO does not have a large enough enrollment to operate this service efficiently in-house.

  A variation on this model which is successful with better educated populations is to establish a cooperative agreement with local community colleges or other adult education programs. Under such an agreement, the HMO staff develops the curriculum and may train the instructor, and the college handles all administrative arrangements, provides the facility, and pays the faculty (65). (The appendix contains a list of one HMO's joint offerings with a local college.) Some IPAs are exploring the possibility of offering educational programs on a fee basis to their fee-for-service patients, in order to recruit adequate numbers of people for group sessions designed for the prepaid members.

- **Contractual arrangements with part-time specialists**
  Some well-defined health education services (e.g., smoking cessation groups) can be delivered effectively by a specialist who provides only that service on a continuous part-time or periodic

TABLE 2: Examples of HMO Health Education and Promotion Staffing and Budgets (June 1981)

	PLAN			
	Multi-Group Health Plan (Wellesley, MA)	Mastercare (Albuquerque, NM)	Valley Health Plan Association (Amherst, MA)	Rhode Island Group Health Association (Providence, RI)
Enrollment	2,500	13,800	15,500	32,000
HMO Type	Group	IPA	Group	Staff
# Sites	5	280 physicians (100 offices)	2	2
Date of Incorporation	1980	1973	1976	1971
Professional FTE	1.0^a	6^a	3.0^a 75 instructors	2.0^a
Functions^{b,c}	1XXX 2X 3XXX 4XXX 5X	1 2 3XX 4XX 5	1XXX 2XX 3XXX 4XXX 5XX	1XXX 2XX 3XXX 4XXX 5X
Budget Allocation (per member per month)	$.81/m/m	$.12/m/m (solely charged to administrative costs)	$.40/m/m — site 1 $.50/m/m — site 2	$.17/m/m

TABLE 2: Examples of HMO Health Education and Promotion Staffing and Budgets (June 1981) (Continued)

	PLAN		
	Genessee Valley Group Health Puget Sound (Rochester, NY)	Group Health Cooperative of Puget Sound (Seattle, WA)	Kaiser-Permanente Medical Care Program (Oakland, CA)
Enrollment	35,000	285,000	1.7 million
HMO Type	Group	Staff	Group
# Sites	2	15	18
Date of Incorporation	1973	1947	1946
Professional FTE	1.0[a]	8.3 1.25 instructors[a]	2.5[a] regional office, 15.5 medical centers, 14.8[a] instructors
Functions[b,c]	1 2X 3XXX 4XX 5X	1XXX 2XX 3XX 4XXX 5XX	1X 2XX 3XXX 4XXX 5XX
Budget Allocation (per member per month)	$.16/m/m (17% of the budget is generated from co-payments)	$.10/m/m (16% of the budget is generated from co-payments)	$.08/m/m

[a] Other participating professionals not located in the health education and promotion cost center are not included; support staff not included.

[b] Categories are: 1) Service utilization, 2) member participation, 3) self-care and patient education, 4) disease prevention and health promotion, and 5) staff and materials development. (See Table 1)

[c] This list includes only those functions carried out under the auspices of the health education and promotion unit.

KEY:		
	xxx	Extensive activity
	xx	Moderate activity
	x	Limited activity
	-	No activity

basis. Voluntary agencies will sometimes provide a group leader or trainer without charge if the HMO provides the facility and recruits participants. Core staff need to maintain continuity with HMO goals, congruence with overall programming, and quality assurance.

- **Use of other HMO staff for part-time educational service**
  Part-time service by HMO staff for special health education roles may be on a release-time or an overtime basis. For purposes of continuity, staff development and morale, and effective use of specialized personnel, such an arrangement may be desirable. A nutritionist who has clinical responsibilities, but who can facilitate behaviorally oriented weight-management groups may be maintained full-time. Nurses with group skills who are given release-time from regular clinic duties to conduct group sessions for new parents bringing infants for a first checkup will be reducing telephone calls and individual visits, as well as enriching their jobs.

Financing and Budgeting

Health education is not a voluntary, cost-free activity to be conducted by zealous practitioners on their own time, nor can it be regarded as a service which must be self-supporting. The budget is a widely used managerial control device, and it has long been recognized as an indicator of organizational commitment to a particular service. Thus, health education and promotion programs require financial resources, and the amount of these resources is a prime determinant of the outcomes that can be achieved. Initial efforts to organize a health education program may include staff time not specifically budgeted for health education. However, the cost of subsequent planning activities needs to be identified and, in most cases, itemized in an identified departmental budget or cost center. Establishment of policies for financing health education services should parallel the development of policy regarding the activities themselves. For example, identifiable costs of clinicians' time used for health education and promotion programs but charged to other budgets sometimes becomes an issue related to capitation and/or other considerations such as sensitivity over the amount charged to administrative overhead in IPAs.

The health education budget should include direct costs, as well as any indirect costs customarily charged to cost centers. Items to consider in budgeting include salaries, expenses, and fringe benefits for personnel; support services; space and facilities rental and maintenance, if needed; equipment (projectors, screens, etc.); educational materials (pamphlets, posters, books, etc.); media software (tapes, films); office supplies (materials, telephone services, postage, etc.); printing, duplicating, and publicity; technical assistance and consultation; recordkeeping and other evaluation expenses (keypunching and other data management, computer time, etc.); staff development expenses (reference materials, journal subscriptions, professional memberships, and continuing education and training); and mileage for local travel.

Major approaches to funding are

- **Annual budget allocation**
  Designated funds are provided for health education and promotion services. The size of this allocation should be commensurate with the objectives for which the unit will be held accountable.
- **Capitation**
  An allocation of the monthly premium is identified for the health education program. Capitation guarantees budgetary adjustments proportional to the size of the HMO membership.
- **Co-payments**
  Certain structured health education programs, notably multisession groups for weight control and smoking cessation, often require small co-payments (112). This may also help screen out those members who are less likely to be committed enough to the program to succeed. Other mechanisms have also been shown to be useful in reducing dropout rates, however, and these may be applied in addition to or instead of co-payments (64).
- **Full fees**
  When programs are open to the community or fee-for-service patients in an open practice, selected programs can be offered to nonmembers for a direct fee. Filling vacancies in a group by recruiting non-HMO members cuts the overhead for members and allows wider diversity in programming.
- **Shared services and contributions**
  The health education director can collaborate with community agencies on various health education projects which promote good will, cooperation, and improved services at lower cost. Examples of this are cardiopulmonary resuscitation training programs carried out in cooperation with the local chapter of the American Red Cross, sexuality education programs sponsored collaboratively with the Planned Parenthood Federation of America, and cancer education programs sponsored in cooperation with local cancer agencies. Volunteer programs do, however, consume resources since they require coordination.
- **Grants and contracts**
  With an organized base and an interest in evaluation and research, opportunities occasionally exist for HMOs to compete for demonstration and evaluation project awards. Technical assis-

tance for developing and improving programs is sometimes available from local universities and college programs and from agencies with expertise in a specific area, such as colostomy management or parenting.

Together with a defined budget allocation, co-payments are the most common contributor to the financial base for health education and promotion programs. Depending upon outside funding for initiating or subsidizing a program practically guarantees staff isolation and a lack of institutional support for the program.

QUALITY ASSESSMENT APPROACHES FOR HEALTH EDUCATION AND PROMOTION PROGRAMS

Documentation

- Medical/Health Records
- Logs and Standard Reports
- Program Activity Reports
- Cost Analysis Reports

Program Evaluation

- Historical Recordkeeping
- Special Inventories
- Comparative Data-keeping
- Controlled Comparison Quasi-Experimental Studies
- Controlled Experimental Studies

External Peer Review

Professional Staff Review

- Review of the Health Education and Promotion Director and Staff
- Review of Other Staff's Health Education Functions

CHAPTER 4

QUALITY ASSURANCE

Quality assessment activities for the health education and promotion program are necessary to ensure that these services represent professional standards of practice, and are efficient, beneficial, accessible, and acceptable to members. Quality assessment methods for these services complement those for personal health services. The following guidelines recommend a quality assurance strategy incorporating assessment procedures for health education programs and staff and health care audits that integrate patient behavior and educational criteria with usual medical criteria. The strategy includes an internal quality assurance program, managed within the HMO; and an external assessment, conducted by an entity not associated with the HMO (113).

Documentation

Documentation is data collection which represents statements of effort: what is done, by whom, when, and how. It is not a measure of a program's outcome, although it can be the basis for such an evaluation. Documentation procedures should be appropriate to the particular educational program activity and consistent with procedures used by other services of the HMO. Major data collection sources and methods are

- **Medical/health records**
  Records should be kept of education conducted as part of the clinical encounter including objectives and pertinent patient and family responses. If a health risk appraisal is a part of the periodic health assessment, recommendation for a plan of action should be explicit (26). In some instances special forms related to educational needs and interventions are inserted in the record. (See the appendix.) Notations of goals and progress should be made by the facilitator of any special educational activities to which a patient is referred or self-referred, e.g., a smoking cessation or a diabetes education group.

- **Logs and standard reports**
  Ongoing records for particular educational activities should be designed to track participant characteristics and outcomes. (See the appendix for an example of a participant log.) Referrals to health education and promotion programs should also be recorded for later analysis of referral patterns and differences in outcome between client- and clinician-initiated referrals. (Examples of referral forms are contained in the appendix.)

  Standardized report forms for health education staff to monitor time allocation and provide data for administrative reports should be developed. (An example of one such form for a large, regionalized HMO appears in the appendix.) While certain health education functions do not easily lend themselves to the "unit of service" concept, health educators should apply the concept where it is appropriate. (The appendix contains examples of a member encounter form and a time and activity document.)

  Documentation of time contributed by staff who assist in carrying out health education programs other than one-to-one clinical encounters may be helpful in monitoring indirect costs and staff involvement for long range planning purposes.

- **Program activity reports**
  Qualitative reports on program planning, implementation, and evaluation processes will help improve and refine program operations, help explain program outcomes, and provide a record for later reference. Such analyses should include the attributes of the program itself, the population involved, the situational context within which the program takes place, and the various kinds of effects produced by the program (114).

  Brief and readable summary reports should be compiled for administrators, key staff, and others who need a grasp of program rationale and progress. This contributes to communication, understanding, and respect, and increases referrals and participation by clinicians.

- **Cost analysis reports**
  Itemization of direct and indirect costs of program activities will contribute data for decisionmaking. If designed carefully, such data can be incorporated into selected cost-effectiveness studies (115). (See the appendix for a cost analysis example.)

Program Evaluation

Program evaluation is a major approach to quality assessment. Evaluation involves a judgment of the value of a program or service.

This is usually made by comparing the program outcomes against a standard. The standard may be historical (what the program achieved in the past), absolute (100 percent), theoretical (what relevant theory and the state-of-the-art literature suggest is reasonable), normative (what similar programs elsewhere usually achieve with similar populations), or comparative (what happened in a similar group that did not receive the program).

What to use as a measure of effectiveness is a major issue. In general, the measure of choice is sustained change in behavior that was targeted during planning. Measurement of intermediate variables (i.e., changes in knowledge, attitudes, and psychomotor skills) is helpful in explaining an outcome and in some areas may be used in lieu of behavior change as the outcome measure. For example, evaluation of an educational program aimed at helping parents cope with an asthmatic child should be concerned with regular adherence to regimen and with emergency room utilization. However, measures of the program's impact on understanding of crucial aspects of the illness, management tactics, and feelings of competency to manage the situation could be used as proxy indicators. Resources are available for assistance with the specification of measures (116) and with qualitative evaluations (117,118).

Below are basic program evaluation designs which can be adapted for differing activities, conditions, and purposes (3):

- **Historical recordkeeping**
  Internal documentation designed according to program objectives will produce a variety of charts, graphs, and tables which can be compared over time. For instance, are dropout rates for the smoking cessation program increasing or decreasing? Was there any change in dropout rate after introduction of the special orientation session to give prospective enrollees in weight reduction groups more information about the techniques and expectations?

- **Special inventories**
  With additional planning and often with little disruption to the service program, more data than is routinely recorded can be collected. For instance, one might want to document whether those people who are referred to a group smoking cessation program by a clinician have a higher cessation rate than those who are self-referred. Collection of baseline data relevant to program outcomes, which is then compared to expected success rates already established in the literature and/or from experience, will point the direction to some fairly convincing and useful, although not fully controlled, evaluation studies.

- **Comparative data keeping**
  In this extension of the recordkeeping and special inventory approaches, data from programs in other organizations, or standardized test results, or norms are used to evaluate results. For instance, does a colleague at another HMO with a similar population using the same smoking cessation curriculum get better cessation rates? What are the normative standards in the literature? (Answer: Approximately 30 percent of self-referred persons are not smoking after 1 year.) How do the results of the HMO's program compare with others?
- **Controlled comparison quasi-experimental studies**
  These studies involve the identification of a group which has similar characteristics to the targeted population but which does not receive the program. One of the first two designs above is applied, and the program outcomes are compared.
- **Controlled experimental studies**
  These are comparable to clinical trials in medical studies and require random assignment of the target population to at least two groups, those who receive the educational intervention and those who do not. Then recordkeeping and special inventory procedures are applied. These studies are usually difficult to accomplish routinely in the service setting, so the evaluator must be very familiar with the principles of the design of such studies (116, 119).

Consideration of which measure or design to use should be based on the developmental phase of the program as well as available expertise and resources. Evaluation of programs in the pilot phase should be aimed at program improvement. Outcome evaluations are best conducted on well-developed programs which are offered to only a part of the potential population to be served. Once a program has been institutionalized, routine monitoring should be sufficient to assure program quality. (See [114] for a discussion of approaches to the timing of program evaluation.)

The health education and promotion director is often in a situation where the demands to provide services are so intense that documentation and evaluation efforts may seem burdensome. The first three evaluation approaches described above are, however, usually practical in the HMO setting. Extensive evaluations may not be justified or necessary when:

- the program is in flux and is undergoing significant modification;
- the literature or experience demonstrates achievement of the normative, acceptable outcome of the program in question (e.g., smoking cessation);
- the cost of a rigorous evaluation would be greater than the program itself;

- the program is desired by members or staff regardless of its effectiveness;
- the current program is the only one feasible and qualitatively appears to be effective.

More extensive evaluation of selected projects, particularly in areas with high potential benefits where interventions have not been tested, is needed and should be considered. The evidence cited in chapter 1 and the criteria for priorities presented in chapter 2 will provide guidance on which programs should be measured against established norms and which programs should receive the attention and resources of a controlled evaluation study. If the expertise is not available inhouse, local colleges and universities can often be brought into cooperative studies.

External Peer Review

External review by professional peers should be conducted periodically onsite to assess the ongoing capability of the HMO to provide quality health education programming. Assessments should be conducted by education specialists experienced in program implementation and review. It is important that consultant expertise be sought during the development phase of an educational program in order to assess the HMO's capabilities and commitment. Additional visits would be indicated when programs are expanding rapidly, when questions arise concerning priorities, as well as when programs are well established and need an independent review. Appraisals for the established program include the program's adherence to usual standards of practice, staffing, policy, and operations, including program planning, implementation, documentation, and evaluation. The visit should include summation conferences with HMO executives and clinical staff and a written report.

Professional Staff Review

Standard personnel performance appraisal mechanisms and medical care review procedures combined with the data from other documentation and evaluation sources will indicate strengths and weaknesses of health education in the HMO. These procedures will identify the needs for continuing or inservice education for individual practitioners and/or groups of professionals, or for procedural changes.

- **Review of the health education and promotion director and staff** Periodic review by supervisors of staff competencies and performance should be based on position descriptions, especially in the case of the director who does not report to someone knowledgeable about the field. If a management-by-objectives system is used, objectives may need to be negotiated periodically to take into account the degree to which an objective was found not to be in control of the health education and promotion director. Also the opportunities for program possibilities may not have been foreseen, resulting in the need to modify objectives.

Feedback surveys from members should include questions about the educational skills of the staff and the content of an educational encounter. (See the appendix for an example of a member feedback form for an educational group and Miller and Lewis [120] for other methods for monitoring leader competence.)

Review of selected activities of health education staff and other staff with health education responsibilities can be greatly facilitated by the delineation of program protocols. Protocols are appropriate for activities with a well-established format and which are conducted by several different staff members where a level of uniformity is desired (see the appendix).

- **Review of other staff with health education and promotion functions**

  Supervisors' periodic reviews of staff competencies and performance should include health education and promotion responsibilities and communication effectiveness. The health education director can help develop criteria.

  Medical care evaluation studies should include explicit, educational criteria when appropriate. For instance, entries related to dietary recommendations, compliance, understanding, and teaching activities have been included in a chart review of hypertensive patients (83). Any audit which focuses on patient outcomes where patient behavior is a factor should have process indicators for patient education (26,87).

  Member surveys should include questions about perceptions of clinicians' educational skills, including efforts to explain the diagnosis and treatment and advice on prevention. Such questions may be part of a general membership survey (20,121), or part of a larger medical care evaluation (18), or research study (122).

Some level of documentation and evaluation is necessary for organizational accountability. Only the level of rigor varies. Accountability and assurance of program quality can be approached through sound management mechanisms. Documentation, professional staff review, external peer review, and the first three program evaluation approaches described are generally appropriate to the HMO setting. Staff supervisors responsible for the review of health education performance of their respective staffs will find that the health education director can help in the setting of review criteria. The quality assurance committee will also benefit from the contributions of the health education director. These procedures will provide the administration, including the health education director, with a profile of achievements, weaknesses, and needs.

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A text that outlines diagnostic steps for planning health education programs of all kinds, and contains valuable information about interventions and their effectiveness under various conditions and in different organizational settings. It contains an extensive bibliography on health education programs and interventions and will be valuable in planning a number of specific programs, as well as for an overview of the planning process for individuals, groups, and institutions.

HEALTH EDUCATION PROJECT ADVISORY COMMITTEE. Making Health Education Work. American Journal of Public Health 65:Supplement, October 1975.

A summary of the experience of over 100 health education programs. Includes some practical examples. Particularly useful for HMOs serving low-income, inner-city, or ethnic minority groups, but can be used by any health educator.

LAZES, P. M. (Editor). The Handbook of Health Education. Germantown, Maryland, Aspen Systems, 1979.

Contains a variety of case studies and guidelines for health education in hospital, HMO, community, workplace, and other settings, including chapters on media and self-care education.

ROGERS, E. M., SHOEMAKER, F. Communication of Innovations: A Cross-Cultural Approach. The Free Press, New York, 1971.

An excellent analysis of the process of communication and change. Provides pragmatic examples.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. A Guide to Health Education in Ambulatory Care Settings. Department of Health, Education, and Welfare, Public Health Service, Health Services Administration, U.S. Bureau of Community Health Services, Rockville, Maryland 20857, DHEW No.(HSA) 78-5501, 1978.

A health education planning guide oriented to ambulatory care and organized by problem areas: preventing illness, consumer recruitment, improving utilization, and increasing adherence to therapeutic regimens. Provides practical steps and numerous examples.

HEALTH MAINTENANCE ORGANIZATIONS

DEAN, D. H. Member Health Education Report: Analysis and Recommendations. Portland, Kaiser-Permanente Health Plan, 1979, 104 pp.

> Example of an inventory and analysis of ongoing activities and needs for health education at a large, staff model HMO. Provides the assumptions, organizational analyses, and linkage to the knowledge base for a 3-year regional plan. Includes the schedule for organization-wide staff interviews and other useful information and forms.

DEEDS, S.G., MULLEN, P.D., (Editors). Managing Health Education in HMOs. Health Education Quarterly, special issue, 8: (In press), 1981 and 9: (In press), 1982.

> A compendium of papers on health education and health promotion in HMOs covering a broad range of issues including management, quality assurance, program development, staffing, organizational structure. Many of the individual papers are cited in the Guidelines.

GALLIHER, C. B., COSTA, M. A. Consumer acceptance of HMOs. Public Health Reports, 90(2): 106–112, 1975.

> This paper examines some experiences in marketing HMOs and puts these experiences into an educational framework that draws upon theory and research findings. The authors consider HMOs an innovation about which the public is largely unaware. Enrollment is a new behavior which requires changes in attitudes and expectations. The article is straightforward, easy to read, and aimed at an audience not already familiar with this basic behavioral science approach.

MULLEN, P. D., KUKOWSKI K., MAZELIS, S. Health education in health maintenance organizations. In: Lazes, P. M. (Editor). The Handbook of Health Education, Germantown, Maryland, Aspen Systems, 1979.

> Presents the results of a study team review of existing activities and programs, including long term recommendations and a 3-year progress report, case studies—management of weight control, smoking cessation, and prenatal classes; matrix management program for prevention; member orientation; and employee training for introduction of a consumer bill of rights.

PARSLEY, J. R. Role of the health educator in developing health education in an HMO. Proceedings of the Group Health Association of America Institute, Los Angeles. Group Health Association of America, Washington, D.C., 1977.

Observations of a health educator who started a program in a small, developing plan.

SHAPIRO, I. S. HMOs and health education. American Journal of Public Health, 65(5): 469–473, 1975.

Provides a rationale for health education in HMOs. There are three sketches of health education as practiced in long-standing HMOs. Topics such as the structure of HMOs, the potential of health education for such settings, and funding needs are reviewed.

SQUYRES, W. D. An overview of health education services. Paper presented to Kaiser Foundation Health Plan and Kaiser Foundation Hospitals Board of Directors, Oakland, 1980.

Describes the history and current programming in health education services in the Northern California Region of Kaiser-Permanente Medical Care Program, including definitions, objectives, rationale, and structure. Several case studies (smoking cessation and stress management) are also presented.

HEALTH PROMOTION/DISEASE PREVENTION

BRESLOW, L., SOMERS, A. R. The lifetime health-monitoring program: a practical approach to preventive medicine. New England Journal of Medicine 296: 601–608, 1977.

Expert panel recommendations for preventive services and counseling for specific age groups. This package contains more services than that of the Canadian Task Force report.

CANADIAN TASK FORCE ON THE PERIODIC HEALTH EXAMINATION. Task force report: the periodic health examination. Canadian Medical Association Journal 121: 1193–1254, 1979.

Report of a 3-year research study of diagnostic and therapeutic procedures, including patient/parent counseling which might be a part of a periodic health examination. Included are a set of age-related health protection packages.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. Department of Health, Education, and Welfare, DHEW(PHS) Pub.No. 79–55071, Number 017–001–00416–2. U.S. Government Printing Office. Washington, D.C., 1979.

The Surgeon General's Report, the major conceptual document for the National Prevention Initiative, describes this country's achievements and opportunities in prevention. The report sets a measurable health goal to be achieved by 1990 for five major age groups, and identifies 15 priority activity areas key to achieving the report's goals. Specific recommendations for action and sources of additional information are included.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. Background Papers. Department of Health, Education, and Welfare, DHEW(PHS) Pub. No. 79-55071A. Number 0.7-001-00417-1. U.S. Government Printing Office. Washington, D.C., 1979.

Background papers prepared under the auspices of the Institute of Medicine, National Academy of Sciences for the Surgeon General's Report.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Promoting Health/Preventing Disease: Objectives for the Nation. Department of Health and Human Services, P.H.S., Washington, D.C., 1980.

Building on the framework of the Surgeon General's Report, measurable objectives have been formulated for each of the 15 priority areas. Data about the extent of the problem, health implications, known interventions and their effectiveness, and data sets for monitoring are identified for hypertension, family planning, pregnancy and infant health, immunization, sexually transmitted diseases, toxic agent control, occupational safety and health, accident prevention and injury control, fluoridation, surveillance and control of infectious diseases, smoking, alcohol and drug abuse, nutrition, physical fitness and exercise, and stress.

INFORMATION SOURCES

NATIONAL HEALTH INFORMATION CLEARINGHOUSE. P.O. Box 1133, Washington, D.C. 20013. 800/336-4797, 703/522-2590 (Virginia only).

Clearinghouse for Federal and other sources of information about a wide range of health topics and materials.

PATIENT AND FAMILY EDUCATION

DEEDS, S. G., HEBERT, B. J., WOLLE, J. M. (Editors). A Model for Patient Education Programming. Washington, D.C., American Public Health Association, 1979.

The new edition of A Model for Patient Education Programming focuses on organizational management at three distinct levels within a hospital or other medical care facilities: institutional, programmatic, and direct patient education. The guide uses an accepted approach to educational program planning for each of the sections. Four aspects of the planning process are discussed: assessing educational needs and resources, planning for educational interventions, implementing the patient education program, and evaluating the program.

HAYNES, R. B., MATTSON, M. E., ENGEBRETSON, T. O. (Editors). Patient Compliance to Prescribed Antihypertensive Medication Regimens: A Report to the National Heart, Lung, and Blood Institute. U. S. Department of Health and Human Services. National Institutes of Health, National Institute of Health Publication No. 81-2102, 1980.

The most recent state-of-the-art report on key behavioral and educational issues affecting compliance to antihypertensive medication regimens. The results of the 11 grants sponsored by the Institute under the National High Blood Pressure Education Research Program were an important component of the data base drawn upon for the report. Chapters cover the role of theory, the study of adherence to regimen, assessment of medication adherence, a review of tested interventions, the clinician/patient relationship, the role of social support, trends in the utilization of strategies to improve adherence, and ethical considerations.

HAYNES, R. B., TAYLOR, D. W., SACKETT, D. L. (Editors). Compliance in Health Care. Baltimore, The Johns Hopkins University Press, 1979.

Contains extensive literature reviews and specific discussions of issues of adherence to therapeutic regimens. The roles of specific professionals, e.g., nurses, pharmacists, and physicians are discussed and patient, family, and situational factors which affect adherence to regimens.

NATIONAL TASK FORCE ON TRAINING FAMILY PHYSICIANS IN PATIENT EDUCATION. Patient Education: A Handbook for Teachers. Society of Teachers of Family Medicine, Kansas City, 1979.

The chapter, Patient Education Primer, gives useful information to assist the health educator undertaking the training of staff in patient education techniques and skills. It provides sample materials to assist clinician learners in setting priorities for patient education with their patients and in structuring their practice to facilitate patient education.

SQUYRES, W. D., (Editor). Patient Education–An Inquiry into the State of the Art. New York, Springer, 1980.

Collection of papers including review of recent evaluations of patient education programs, quality assessment of patient education programs, behavioral self-management strategies, and issues related to the goals of patient education.

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE. Media Handbook. Center for Disease Control, Bureau of Health Education, Atlanta 30333, 1980.

An introductory reference for selecting, producing, and using media in patient education programs. Lists the advantages and disadvantages of models, programmed material, audio recordings, instructional television, and other types of media. Describes simple production techniques. Puts media into the context of an overall program plan.

QUALITY ASSURANCE

CAMPBELL, D. T., STANLEY, J. C. Experimental and Quasi-Experimental Designs for Research. Chicago, Rand McNally, 1967.

Outlines and discusses statistical models of research which can be applied to program evaluation. Appropriate for use by those with a background in statistics.

COOK, T. D., CAMPBELL, D. T. Quasi-Experimentation Design and Analysis Issues for Field Settings. Chicago, Rand McNally, 1979.

Presents quasi-experimental designs and appropriate analytic techniques used to examine causal hypotheses in basic and applied research. Useful to those with some research, evaluation and statistics background.

DENISTON, O. L., ROSENSTOCK, I. M., WELCH, W., GETTING, V. A. Evaluation of Program Efficiency. Public Health Reports 83: 603-610, 1968.

Complex and technical article. If worked through carefully, can be very useful in writing objectives and evaluating programs.

GREEN, L. W., BROOKS-BERTRAM, P. Peer review in quality control in health education. Health Values 2: 191-197, 1978.

A helpful discussion of quality control issues in health education with suggested criteria for the evaluation of program structure and process. Developed earlier by the senior author in collaboration with Marjorie A.C. Young and Ralph Solad. These are criteria for problem diagnosis, planning, and implementation.

APPENDIX

Part 1.—Legal Mandate and Selected Literature
- Example of State Requirements
- Effects of Psychological Preparation for Surgery on Hospital Behavior (Suffering) and Recovery (Healing)

Part 2.—Sample Forms and Protocols
- Provider Survey Forms
- Committee Description
- Member Survey Forms
- Program Inventory Forms
- Departmental Objectives (Annual)
- Educational Protocols
- Physician Newsletter
- Position Descriptions
- Community Programs Schedule
- Medical Record Forms
- Program Monitoring Forms
- Referral Forms
- Report Forms
- Cost Analysis Report
- Course Evaluation Forms

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APPENDIX

PART 1

LEGAL MANDATE AND SELECTED LITERATURE

Legal Mandate and Selected Literature—Example of State Requirements

- Medical Service Standards

Source—State of California Department of Corporations

Medical Service Standards Under the Knox-Keene Health Care Service Plan Act of 1975

12.2: "There shall be effective health education services including information on a) personal health behavior and health care, b) recommendations regarding the optimal use of care services provided by the plan and its affiliates."

12.3: "The plan shall designate a health education specialist who shall be responsible for the development and coordination of health education activities. This shall be a full-time, part-time or consultation basis."

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APPENDIX

PART 2

SAMPLE FORMS AND PROTOCOLS

Sample Forms and Protocols—Provider Survey Forms
- Health Education Questionnaire

Source—Health Central, Lincoln, Nebraska

HEALTH EDUCATION QUESTIONNAIRE

Staff input is both necessary and invaluable in planning and implementing a successful health education program. Response to the following questions will be used in formulating a comprehensive health education plan.

1. Identify at least three common health problems for which Health Central clients are seen by you. Please list.

2. What frequently encountered health problems seen by you would most benefit from health education? Please list a minimum of three.

3. What type of health education services do you feel would be most helpful to Health Central clients?

____

____

4. What do you presently feel are some of the difficulties in providing health education to clients? Please indicate only the top three in your estimation.

_______ Not enough time
_______ Lack of patient interest
_______ Not enough educational services currently available
_______ Not sure what the health education program provides
_______ Not sure if health education can help
_______ Other (Please Specify)_______________________

5. What kinds of educational materials do you feel would be most useful to clients? Please list.

____

____

6. What type of assistance do you expect to be provided with by the health education program? Please specify.

____

____

7. What health subject areas are you most willing to provide assistance with regarding patient education? Please specify.

____

____

Sample Forms and Protocols—Provider Survey Forms
- Provider Survey on Health Education

Source—The Philadelphia Health Plan, Pennsylvania

THE PHILADELPHIA HEALTH PLAN PROVIDER SURVEY ON HEALTH EDUCATION

There are two purposes of the survey: (1) to determine the health education services that are being provided throughout the Philadelphia Health Plan (PHP); and (2) to determine what additional materials, services, or programs that you would like to have provided by both your Medical Group and PHP.

PHP subscribes to the following definition of health education (which is from a position paper of the American Public Health Association):

> "Health education can help to prepare people to take greater responsibility for their own health and that of their families and communities. Through health education, individuals acquire the information, skills, and values for making responsible decisions about their personal health....the goal of health education is the health-educated consumer-citizen who adopts a health-promoting lifestyle, wisely selects and uses health care resources, products, services, and influences public policy and planning on health care issues and larger environmental matters that affect health...."

DIRECTIONS: PLEASE CHECK THE BEST ANSWER IN THE SPACE PROVIDED, UNLESS OTHERWISE INDICATED.

1. Name:______________________________
   Title:______________________________

2. Area(s) of Specialty/Interest:____________________

3. Name of Medical Group:____________________

4. How many hours per week do you spend one-on-one with patients (inpatients and outpatients)? ____________________

5. What percentage of the "hours per week you spend with patients" is devoted to each of the following activities?

ACTIVITIES	PERCENTAGE
History/information gathering	__________
Examination	__________
Task/procedures	__________
Diagnosis/patient instructions	__________
Health education	__________

6. Would you be interested in receiving a resource book listing outside referrals (e.g., Weight Watchers) which PHP would develop for providers? Yes______ No______

7. Would you use the resource book? Yes______ No______

8. The two most recent issues of "TO YOUR HEALTH" (9 and 10) included information and/or self-evaluation quizzes in the following areas: joint/muscle flexibility, home medicine cabinet, smoking, dental health, stress, and a good breakfast. Please check the appropriate space in terms of your feelings of "relevance for subscribers."

Areas	Relevant	Not Relevant	Not Sure
a. Joint/muscle flexibility	______	______	______
b. Home medicine cabinet	______	______	______
c. Smoking	______	______	______
d. Dental health	______	______	______
e. Stress	______	______	______
f. A good breakfast	______	______	______

9. Do you have any general comments about "TO YOUR HEALTH?" (including future subject matter)____________

____

10. Do subscribers comment to you on PHP courses/seminars/or "TO YOUR HEALTH?" Yes______No______
Comments:__________________________________

____

11. Do you think that PHP should encourage the use of home monitoring blood pressure equipment?

a. Patients with high blood pressure Yes ____ No ____
b. Patients with normal blood pressure Yes ____ No ____

12. As you know, PHP and/or the Medical Groups sponsor multi-session courses and single-evening seminars. Would you be willing to help teach or volunteer as a speaker for these activities? Yes ____ No ____

13. If you answered "Yes" in question 12, please complete the following: According to a recent health education survey, PHP subscribers selected the following courses/seminars that they "would participate in." Please indicate the course(s)/seminar(s) you could help teach, including any areas of special interest to you that we have overlooked.

COURSES

Physical fitness ___
Weight reduction ___
Stop smoking program ___
Medical self-care ___
Exercise/dance class ___
Yoga class ___
Childbirth education ___
Hypertension ___
Diabetes ___
Other:__________ ___

SEMINARS

Coping with stress ___
Common medical emergencies ___
Cardiopulmonary resuscitation ___
Nutrition counseling ___
Physical fitness ___
Vegetarian eating ___
How to be a good parent ___
Other:__________ ___
____________________ ___
____________________ ___

14. What health education services do you think that PHP should provide? ______________________________

____

15. What health education services do you think that your Medical Group should provide? ______________________________

____

16. Would you be interested in serving on a small joint PHP/Medical Group advisory committee to help plan PHP's overall approach and strategy to health education? Yes ____ No ____

17-18 (See following pages)

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EFFECTS OF PSYCHOLOGICAL PREPARATION FOR SURGERY ON HOSPITAL BEHAVIOR (SUFFERING) AND RECOVERY (HEALING)*

Type of Preparation	Investigator	Type of patient	Outcome	
			Suffering	Duration of Hospital Stay
Coping	Johnson (1965)	Abdominal surgery	No effect on self-rating of pain	1.14 days shorter
	Healy (1968)	Mixed surgical	Fewer analgesics	Shorter
	Lindeman and Van Aernam (1967)	Mixed surgical	Better ventilatory functions, no effect on medication	1.9 days shorter
	Johnson and Leventhal (1974)	Gastrointestinal endoscopy	Fewer tranquilizers, stable heart rate, less gagging	—
	Langer et al. (1975)	Abdominal surgery	Fewer analgesics	1.87 days shorter
	Chapman (1969)	Hernia	No effects on biochemical measures, fewer analgesics	—
	Putt (1970)	Peptic ulcer	No effect on anxiety, less distress	Significantly shorter
Information	Lindeman and Stetzer (1972)	Mixed surgical	Less postoperative anxiety, no difference in medication	No difference
	Johnson (1972)	Gastrointestinal endoscopy	Fewer tranquilizers required	—
	Johnson and Leventhal (1974)	Gastrointestinal endoscopy	Reduction in tranquilizers, less gagging, stabilization of heart rate	—
	Williams et al. (1975)	Termination of pregnancy	High-anxiety patients reduced anxiety, low-anxiety patients increased anxiety	—
	Langer et al. (1975)	Abdominal surgery	No effect on analgesics	No difference

			Outcome	
Type of Preparation	Investigator	Type of patient	Suffering	Duration of Hospital Stay
Quasi-psychotherapy	Chapman (1969)	Hernia	No effects on biochemical measures, fewer analgesics	1.7 days shorter
	Putt (1970)	Peptic ulcer	No effect on anxiety, less distress	Shorter (longer, however, than with informational preparation)
	Williams et al. (1975)	Termination of pregnancy	Reduced preoperative anxiety	–
Coping and Information	Egbert et al. (1964)	Abdominal surgery	No effect on self-rating of pain, fewer analgesics	2.7 days shorter
	Johnson (1965)	Abdominal surgery	No effect on self-rating of pain	1.14 days shorter
	Schmitt and Woolaride (1973)	Mixed surgical	Better sleep, less anxiety, lower rise in BP, lower rise in pulse, fewer urination difficulties, and fewer analgesics	2.1 days shorter
	Johnson and Leventhal (1974)	Gastrointestinal endoscopy	Stabilization of heart rate, less gagging	–
	Langer et al. (1975)	Abdominal surgery	Increased passage of tube, reduction of analgesics	–
	Newton and Reading (1977)	IUD insertion	Reduction of pain at insertion	–

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*Source of table: READING, A. E. The short term effects of psychological preparation for surgery. Social Science and Medicine 13A: 645, 1979.

Sample Forms and Protocols—Committee Description

- Education Advisory Committee

Source—Rhode Island Group Health Association, Providence, Rhode Island

EDUCATION ADVISORY COMMITTEE

Purpose: To establish a multidisciplinary advisory committee to develop a comprehensive approach for the coordination of both patient education and inservice education at Rhode Island Group Health Association (RIGHA).

The establishment of the Education Advisory Committee would eliminate the need for separate committees for Health Education and Inservice Education, thus reducing duplication while maintaining appropriate representation.

Goals:
1. Identify and assess the needs for consumer and staff education.
2. Select priorities among the needs.
3. Review plans for development, implementation, and evaluation of education programs and other education services.
4. Stimulate awareness and involvement in education at RIGHA.

Membership: The Education Advisory Committee is designed on a multidisciplinary basis to recognize and promote the viewpoints, roles, functions, and contributions of the entire staff of RIGHA Group Health Association.

Committee structure should be large enough to be representative of the major service areas and small enough to be functional. (Although the entire RIGHA staff can be utilized as a resource, the majority of responsibilities outlined will be performed by this committee).

The number of active participants should probably not exceed twenty. Staff to the committee will be Debra Salzberg, Jeannine Rivet, and Carol Waters.

Committee members should have a sincere interest and commitment to the promotion of education services at RIGHA and should be willing to attend meetings regularly.

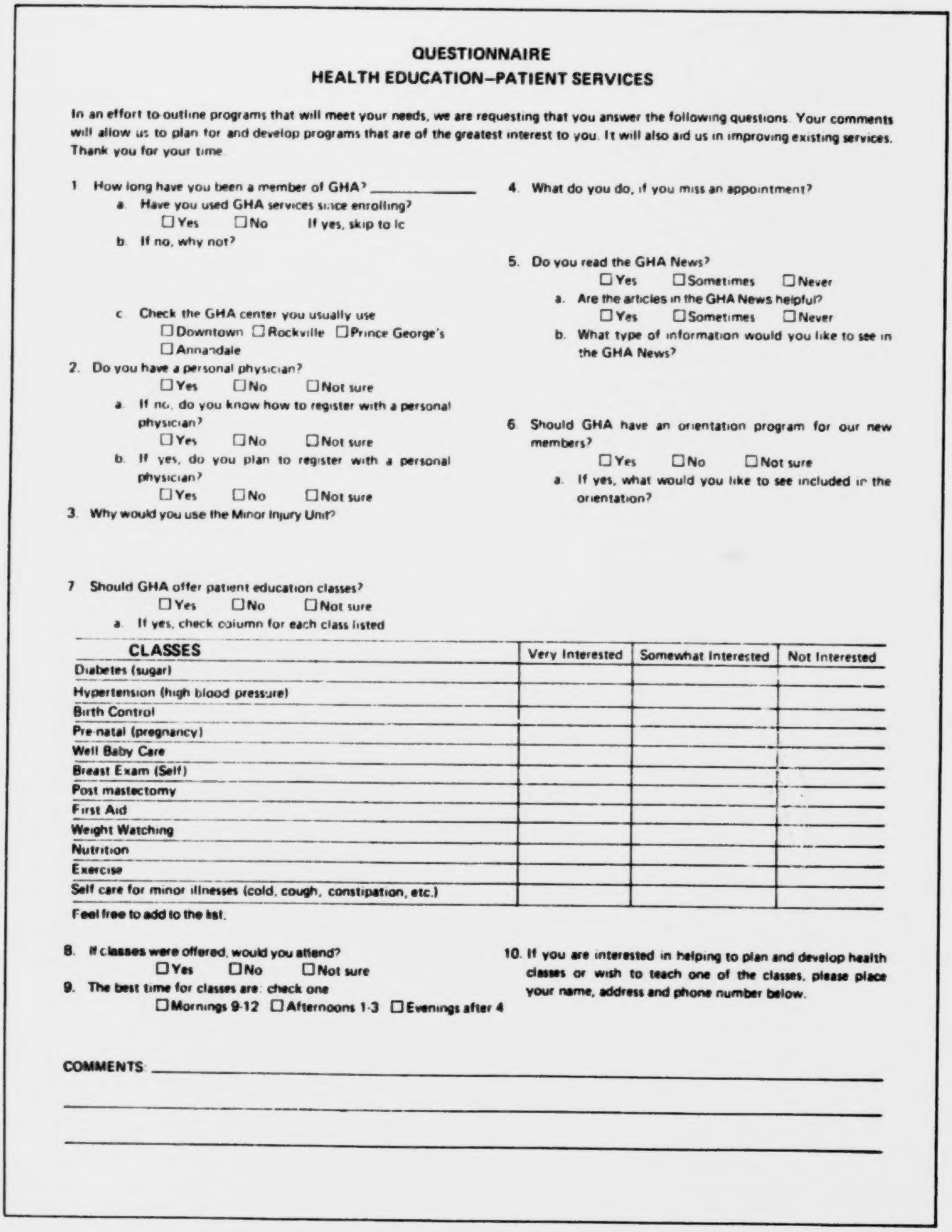
Meetings: The Education Advisory Committee will meet on a regular monthly basis for one hour, or when called by the chairperson.

Responsibilities:
1. Review agenda item materials before meetings.
2. Submit ideas for agenda items.
3. Review, comment, and make suggestions on education program outlines, literature, films, and other audio-visuals.
4. Chair or serve on sub-committees for program development or special projects.

Sample Forms and Protocols—Member Survey Forms

- Questionnaire—Health Education—Patient Services

Source—Group Health Association, Washington, D.C.



QUESTIONNAIRE
HEALTH EDUCATION–PATIENT SERVICES

In an effort to outline programs that will meet your needs, we are requesting that you answer the following questions. Your comments will allow us to plan for and develop programs that are of the greatest interest to you. It will also aid us in improving existing services. Thank you for your time.

1. How long have you been a member of GHA? ____________
   a. Have you used GHA services since enrolling?
      ☐ Yes ☐ No If yes, skip to Ic
   b. If no, why not?
   c. Check the GHA center you usually use
      ☐ Downtown ☐ Rockville ☐ Prince George's ☐ Annandale
2. Do you have a personal physician?
   ☐ Yes ☐ No ☐ Not sure
   a. If no, do you know how to register with a personal physician?
      ☐ Yes ☐ No ☐ Not sure
   b. If yes, do you plan to register with a personal physician?
      ☐ Yes ☐ No ☐ Not sure
3. Why would you use the Minor Injury Unit?
4. What do you do, if you miss an appointment?
5. Do you read the GHA News?
   ☐ Yes ☐ Sometimes ☐ Never
   a. Are the articles in the GHA News helpful?
      ☐ Yes ☐ Sometimes ☐ Never
   b. What type of information would you like to see in the GHA News?
6. Should GHA have an orientation program for our new members?
   ☐ Yes ☐ No ☐ Not sure
   a. If yes, what would you like to see included in the orientation?
7. Should GHA offer patient education classes?
   ☐ Yes ☐ No ☐ Not sure
   a. If yes, check column for each class listed

CLASSES	Very Interested	Somewhat Interested	Not Interested
Diabetes (sugar)			
Hypertension (high blood pressure)			
Birth Control			
Pre-natal (pregnancy)			
Well Baby Care			
Breast Exam (Self)			
Post mastectomy			
First Aid			
Weight Watching			
Nutrition			
Exercise			
Self care for minor illnesses (cold, cough, constipation, etc.)			

Feel free to add to the list.

8. If classes were offered, would you attend?
   ☐ Yes ☐ No ☐ Not sure
9. The best time for classes are: check one
   ☐ Mornings 9-12 ☐ Afternoons 1-3 ☐ Evenings after 4
10. If you are interested in helping to plan and develop health classes or wish to teach one of the classes, please place your name, address and phone number below.

COMMENTS: ____

____

____

Source—Health Central, Lincoln, Nebraska

HEALTH EDUCATION QUESTIONNAIRE

Your response to the following questions will greatly assist Health Central in providing you with the services you desire. We sincerely appreciate your cooperation.

AGE: ______

SEX: ______

RESPONDING FOR: JUST YOURSELF______ OR FAMILY AND YOURSELF______

1. During your visits to Health Central, do you feel that the information you receive about your heath problem is: (Please check one)
   - ____ Excellent
   - ____ Adequate
   - ____ More than I need to know
   - ____ Less than I need to know

2. About what kinds of health problems would you like to receive more information or educational assistance? (PLEASE CHECK ONLY 5)
   - ____ Arthritis
   - ____ Birth control
   - ____ Breast self-exam
   - ____ Dealing with minor health problems
   - ____ Diabetes
   - ____ Exercise
   - ____ First aid
   - ____ High blood pressure
   - ____ Parenting
   - ____ Proper nutrition
   - ____ Sexuality: Adult
   - ____ Sexuality: Teenage
   - ____ Smoking
   - ____ Stress reduction
   - ____ Weight reduction

   Other:______________________________

3. Where do you receive most of your health information? Please rank the top 4 items. (1 is the most frequent, 2 is the second most,...4 is the least)

____ Books
____ Church
____ Family
____ Friends
____ Health department
____ Hospital
____ Newspapers
____ Health Central nurses
____ Health Central physicians
____ Radio
____ School
____ T.V.
____ Voluntary
(Am. Heart Assoc.,Am. Cancer
Society, etc.)
____ Other Health Central professionals
(besides nurses and physicians)

4. What type of health education services would be most helpful to you? (PLEASE CHECK ONLY 4)
____ Classes
____ Individual consultation
____ Printed materials to
take home
____ Written instructions
from a health provider
____ A lending library of health publications
____ Films and other audio-visuals
____ Articles in the Health Central newsletter
____ Other____________________

5. Do you need to know anything about the services offered at Health Central? Yes ____ No ____

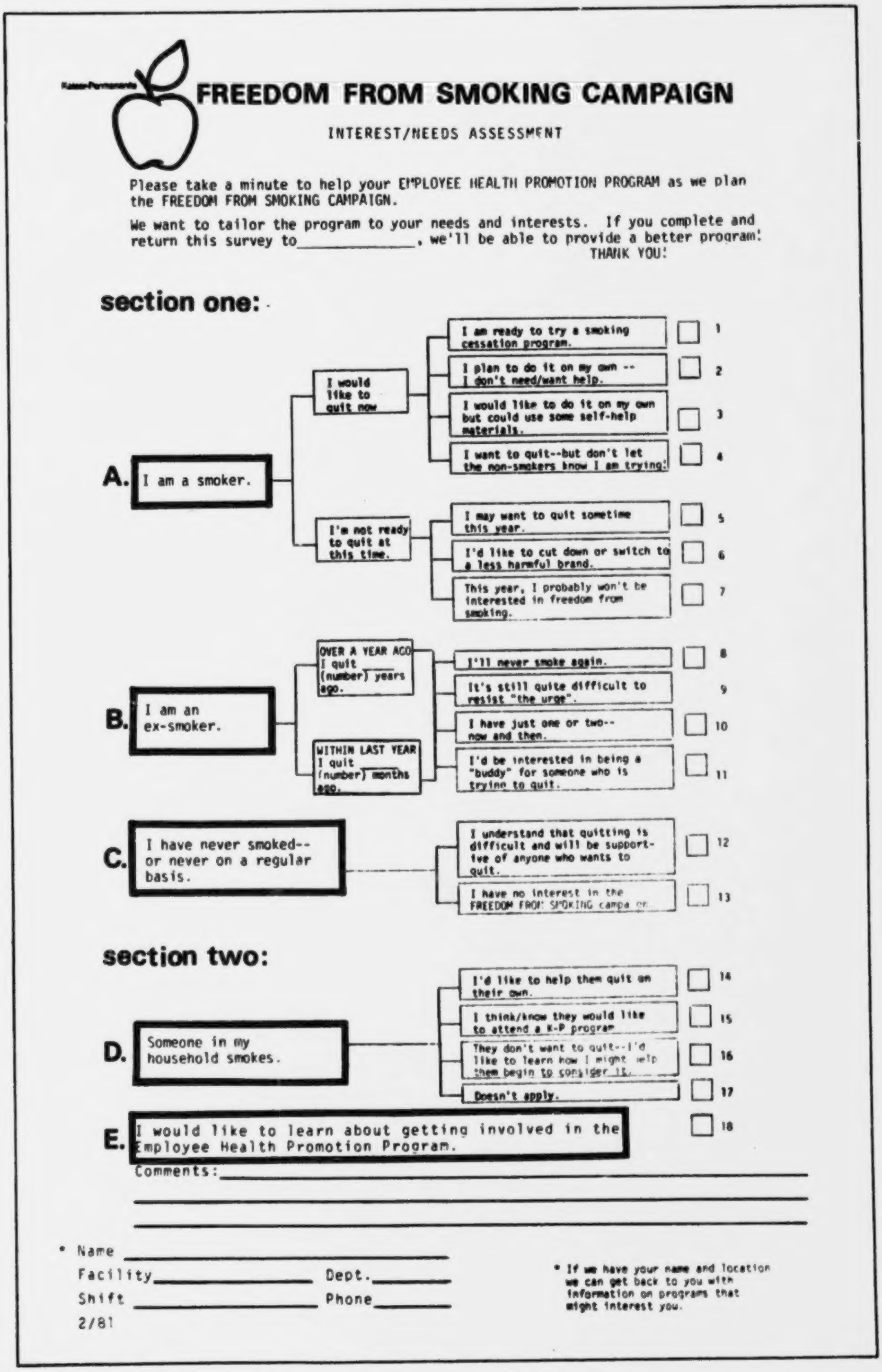
6. If yes, to the previous question, please specify what you would like to know?

____

Sample Forms and Protocols—Member Survey Forms

- Freedom from Smoking Campaign, Interest/Needs Assessment

Source—Kaiser-Permanente Medical Care Program, Oregon Region, Portland, Oregon.



Kaiser-Permanente

FREEDOM FROM SMOKING CAMPAIGN

INTEREST/NEEDS ASSESSMENT

Please take a minute to help your EMPLOYEE HEALTH PROMOTION PROGRAM as we plan the FREEDOM FROM SMOKING CAMPAIGN.

We want to tailor the program to your needs and interests. If you complete and return this survey to____________, we'll be able to provide a better program!
THANK YOU!

section one:

A. I am a smoker.

- I would like to quit now
  - I am ready to try a smoking cessation program. ☐ 1
  - I plan to do it on my own -- I don't need/want help. ☐ 2
  - I would like to do it on my own but could use some self-help materials. ☐ 3
  - I want to quit--but don't let the non-smokers know I am trying! ☐ 4
- I'm not ready to quit at this time.
  - I may want to quit sometime this year. ☐ 5
  - I'd like to cut down or switch to a less harmful brand. ☐ 6
  - This year, I probably won't be interested in freedom from smoking. ☐ 7

B. I am an ex-smoker.

- OVER A YEAR AGO I quit ____ (number) years ago.
- WITHIN LAST YEAR I quit ____ (number) months ago.
  - I'll never smoke again. ☐ 8
  - It's still quite difficult to resist "the urge". 9
  - I have just one or two-- now and then. ☐ 10
  - I'd be interested in being a "buddy" for someone who is trying to quit. ☐ 11

C. I have never smoked-- or never on a regular basis.

- I understand that quitting is difficult and will be supportive of anyone who wants to quit. ☐ 12
- I have no interest in the FREEDOM FROM SMOKING campaign. ☐ 13

section two:

D. Someone in my household smokes.

- I'd like to help them quit on their own. ☐ 14
- I think/know they would like to attend a K-P program ☐ 15
- They don't want to quit--I'd like to learn how I might help them begin to consider it. ☐ 16
- Doesn't apply. ☐ 17

E. I would like to learn about getting involved in the Employee Health Promotion Program. ☐ 18

Comments:______________________________________

* Name ____________________

Facility____________ Dept._______

Shift ____________ Phone_______

2/81

* If we have your name and location we can get back to you with information on programs that might interest you.

Sample Forms and Protocols—Program Inventory Forms

- Inventory of Patient/Member Education Activities—Small Group Interview in Medical Offices

Source—Kaiser-Permanente Medical Care Program, Portland, Oregon

INVENTORY OF PATIENT/MEMBER EDUCATION ACTIVITIES—SMALL GROUP INTERVIEW IN MEDICAL OFFICES

1. (a) What patient education programs or activities do you offer here at

____________________?

	Most Enthused
________________________________	☐
________________________________	☐
________________________________	☐
________________________________	☐

(b) Which activities or programs are you most enthused about? (Check above) Why?

____

(c) Are they still going on? (If not, why not?)

____

2. (a) Who put the programs together?

____

(b) Did they work with anyone else in Kaiser-Permanente in preparing the Program? ☐ Yes ☐ No Who?________

3. (a) What programs or activities have you been wanting to get started?

____

80

The Philadelphia Health Plan Provider Survey on Health Education (Continued)

17. What health education service(s) do you perform for each of the following subjects?

USE A "1" IF YOU NOW PERFORM THESE SERVICES.
USE A "2" IF YOU WOULD LIKE TO SEE THEM OFFERED IN THE FUTURE.
LEAVE BLANK IF NEITHER APPLIES.

	Discuss health problem(s) with subscriber	Refer subscriber to appropriate resources (e.g., texts, articles)	Refer subscriber to Medical Group seminar/course	Refer subscriber to PHP seminar/course	Refer subscriber to outside help (e.g., Weight Watchers)	Hand out written material	Audio-visual material	Use teaching modules (e.g., instructional booklets)
Alcohol/drug abuse								
Allergies								
Auto safety (e.g., seat belt use)								
Birth control/VD								
Breast self-exam								
Cancer								
Cardiac risk factors/stroke								
Childbirth education								
Dental health								
Diabetes								
How to read prescriptions								
Hypertension								
Life style/health promotion								
Marital problems								
Medical emergencies								
Mental health (e.g., depression)								
Nutrition								
Parenting								
Physical fitness								
Self-care skills								
Sex education								
Smoking								
Sports medicine								
Stress management								
Other:								

18. We would like to have your evaluation of the following areas of health education emphasis in terms of POTENTIAL BENEFITS TO YOUR MEDICAL GROUP (e.g., proper utilization of Medical Group, improved health status of members), and POTENTIAL EFFECTIVENESS OF HEALTH EDUCATION EFFORT ON SUBSCRIBERS (see page 1 for definition of health education). For each column (A and B), please check the best answer (high, moderate, low) for each area of emphasis.

	A. BENEFIT TO MEDICAL GROUP			B. EFFECTIVENESS OF HEALTH EDUCATION		
	HIGH	MODERATE	LOW	HIGH	MODERATE	LOW
a. Smoking cessation						
b. Smoking prevention						
c. Nutrition counseling						
d. Physical fitness						
e. Weight reduction						
f. Defensive driver training						
g. Home safety practices						
h. Occupational safety practices						
i. Child abuse counseling						
j. Immunization visits						
k. Natural childbirth training						
l. Pre and post-natal visits						
m. Contraceptive counseling						
n. Genetic counseling						
o. Breast self-exam						
p. Self-care						
q. Annual physical exam						
r. Multiphasic screening (low risk groups)						
s. Diabetes control						
t. Hypertension control						
u. Hypertension screening						
v. Compliance with medical regimes						
w. Drug abuse						
x. Life style modification						
y. Non-urgent visits to clinics						
z. Post-heart attack stress control						

RETURN QUESTIONNAIRE TO YOUR MEDICAL DIRECTOR NO LATER THAN ______________

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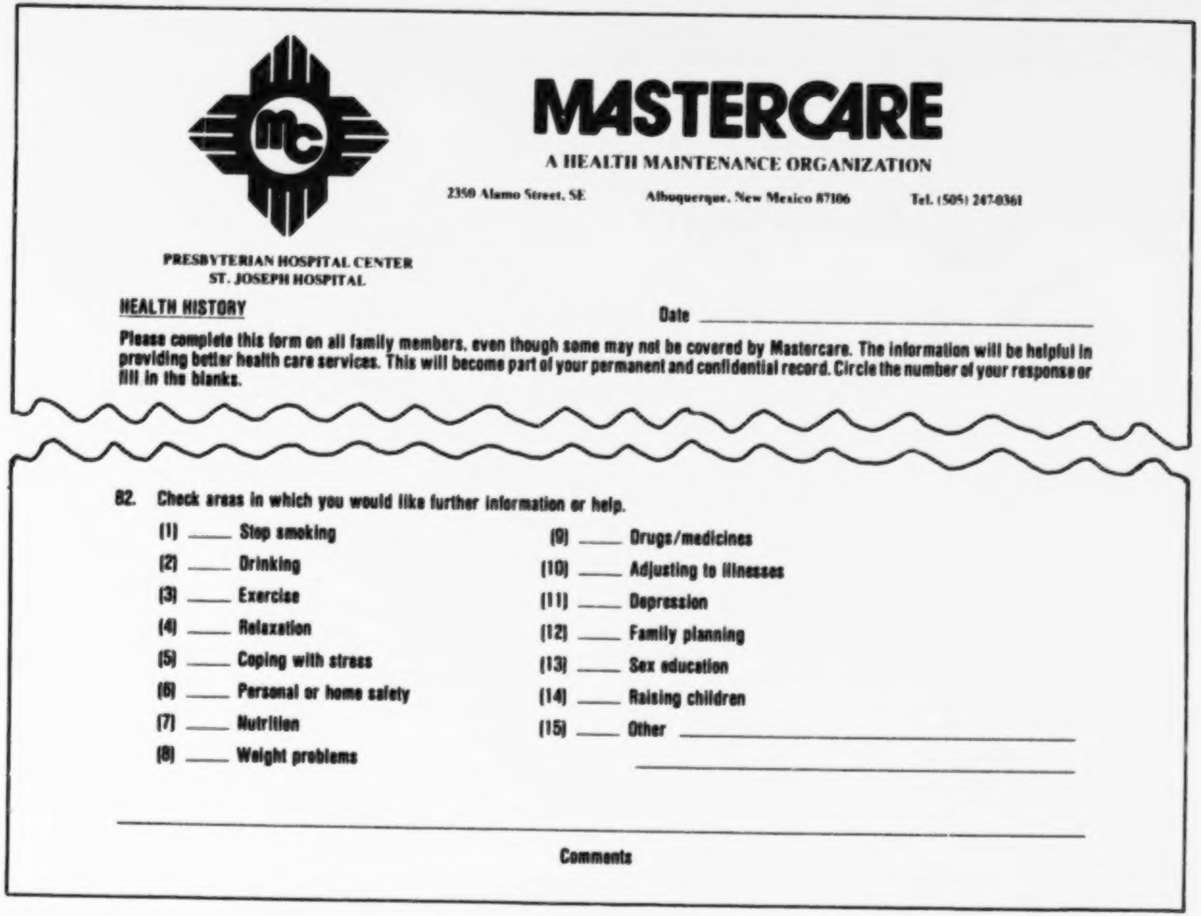
Sample Forms and Protocols—Member Survey Forms
- Question from Health History Questionnaire

Source—Mastercare, Albuquerque, New Mexico



MASTERCARE

A HEALTH MAINTENANCE ORGANIZATION

2350 Alamo Street, SE   Albuquerque, New Mexico 87106   Tel. (505) 247-0361

PRESBYTERIAN HOSPITAL CENTER
ST. JOSEPH HOSPITAL

HEALTH HISTORY

Date ______________________

Please complete this form on all family members, even though some may not be covered by Mastercare. The information will be helpful in providing better health care services. This will become part of your permanent and confidential record. Circle the number of your response or fill in the blanks.

82. Check areas in which you would like further information or help.

(1) ____ Stop smoking
(2) ____ Drinking
(3) ____ Exercise
(4) ____ Relaxation
(5) ____ Coping with stress
(6) ____ Personal or home safety
(7) ____ Nutrition
(8) ____ Weight problems
(9) ____ Drugs/medicines
(10) ____ Adjusting to illnesses
(11) ____ Depression
(12) ____ Family planning
(13) ____ Sex education
(14) ____ Raising children
(15) ____ Other ______________________
____

____

Comments

(b) Reason why: high risk members; repeater; expensive to treat; good prevention.

____

4. (a) In your estimation, what percentage of patients counseled individually are given written material (handouts) to reinforce the verbal advice? ______ %

(b) Are you satisfied with the quality?

____

(c) System for dispersal?

____

(d) Frequency and consistency of usage?

____

5. For the following individuals, estimate what percentage of each clinic visit is spent doing patient/member education.

______ % M.D.
______ % Office Nurse
______ % Pharmacist
______ % Advice Nurse
______ % Social Worker
______ % Other

6. Are there changes you'd like to see in this allocation of time for patient education?

____

7. (a) What audio-visual material do you have available?

____

(b) How often do you feel the audio-visual materials you now have are being used?

____

(c) How are they assessed?

☐ Patient directly ☐ staff assist ☐ special room
☐ Other________________________________

(d) Is that a problem?

____

8. To strengthen existing programs, what would you like to see happen?

____

9. Have you had any problems/concerns in developing your patient education programs?

____

10. In planning or implementing your programs, what assistance would be most valuable to you?

____

11. Are there any other Kaiser-Permanente facilities that are doing or planning a member/patient education project related to those you have here?

____

12. How do you feel about that? (Are there ways this could be used to your advantage?)

____

13. What member education on how to use the system occurs in your facility?

____

14. Who usually does it?

☐ Receptionist
☐ Cashier
☐ Nurse
☐ Physician
☐ Pharmacist

15. Is this mostly one-to-one? ☐ Yes ☐ No

16. What usually prompts this "educational session"?
   - Planned for new members ☐
   - Patient request ☐
   - Patient misuse of system ☐
   - Observation of patient need for help ☐

17. How satisfied are you with the way things go now regarding teaching the members to use the system?

1	2	3	4	5
very satisfied	satisfied	so-so	dissatisfied	very dissatisfied

18. Are there any additional comments or questions you might wish to share?

Sample Forms and Protocols—Program Inventory Forms
- Inventory of Current Patient/Member Educational Programs

Source—Kaiser-Permanente Medical Care Program, Oregon Region, Portland, Oregon

INVENTORY OF CURRENT PATIENT/ MEMBER EDUCATIONAL PROGRAMS*

1. Department(s)________________________________

2. (a) Educational program title________________________
   (If more than one program, please complete a separate questionnaire for each program.)
   (b) Currently operational ☐ Planned for near future ☐

3. What is the purpose of the program? (25 words or less)
   ____

4. How did you decide the program was needed?
   ____

5. What is the client-patient population?
   ____

---

*See cover memo for definition (not included in the appendix).

6. How does the member/patient enter program?

☐ M.D. Referral
☐ M.D. Suggestion
☐ Self Referral
☐ Other (Explain)

Learned of Program from:

☐ Posters Brochures
☐ Newspaper
☐ Healthgram
☐ Other __________
____
____
____
____

7. What educational materials and methods do you use?
   - ☐ films
   - ☐ cassettes, slides
   - ☐ pamphlets
   - ☐ "home-designed" handouts
   - ☐ posters
   - ☐ classes
     - ☐ lecture/question and answers
     - ☐ lecture/discussion
     - ☐ peer support groups
     - ☐ family, friends instruction included
   - ☐ one-to-one counseling: how often__________
   - ☐ other

____

8. Description of the program
   (a) How many sessions are there in each "program"?__________
   (b) How often is the program offered?__________
   (c) Where is it offered?__________
   (d) How many participants, on an average, attend?__________
   (e) Briefly describe the educational program (25 words or less)

____

9. Who is mainly responsible for program?

____

10. Who are the main teachers or instructors? (names and professions)

____

11. What percentage of each of their time would you estimate is spent preparing and teaching?

____

12. If you have written goals and objectives for this program, state them below (or attach a copy).

____

13. If goals are not specifically written down—can you briefly summarize them in your own words?

____

14. (a) Do you do any followup to check what or whether the patient really learned? Yes ☐ No ☐

(b) If yes, describe it briefly.

____

15. Is the program open to members only? ☐ Yes ☐ No

16. Is there a fee for the program?

Yes ☐ co-pay/member/amount__________ ☐ No
co-pay/nonmember/amount________

Other________________________

17. (a) Does the fee cover the expenses of the program?
☐ Yes ☐ No

(b) If not, how is program supported?

____

18. Is this program oordinated with any other Kaiser-Permanente or community program? ☐ Yes ☐ No Explain:

____

19. Have you had any problems or concerns in developing your patient education program?

____

20. In planning or implementing your programs what assistance would be most valuable to you?

____

21. (a) What other programs or activities have you been wanting to get started or see developed?

____

(b) Reason why: high numbers; repeaters; expensive to treat; good prevention?

____

22. If possible, please attach any materials, handouts, etc. used in the program.

23. Are there any additional comments, questions, you might wish to share? (Use back of sheet, if necessary)

____

Sample Forms and Protocols—Departmental Objectives (Annual)

- Health Education Department, 1979 Objectives

Source—Group Health Cooperative of Puget Sound, Seattle, Washington

HEALTH EDUCATION DEPARTMENT

1979 OBJECTIVES

Revised January 10, 1979

	Measurements*		
1979 OBJECTIVES	P.	R.	O.
1. Develop in one medical center in each region a comprehensive education program which includes education for consumers, patients and employees and integrates current educational efforts.			
Measurement: Needs Assessment Conducted	5/79	4/79	3/79
Measurement: Overall Medical Center Plan for Education Developed	7/79	6/79	5/79
Measurement: Number of Programs Integrated	5	7	9
2. Assure the development of information for consumers and training for employees to contribute to the improvement of access to GHC services:			
a. Identify and respond to problems and educational needs of consumers and employees which may be brought about by policy, procedure or system changes.**			

---

*P = pessimistic; R = realistic; O = optimistic estimates.

**Changes anticipated in 1979 are: 1) Sound Health acquisition/transition project; 2) Eastside Hospital OB unit opening; 3) Opening of new specialty center in Tacoma; 4) Opening of GHC abortion clinic; 5) Development of new clinics in Factoria, Kenmore and Rainier Valley; 6) Expansion of Clinics in Olympia and Federal Way and Northgate; 7) Opening of Capitol Mini-Clinic; 8) Implementation of the Panel System; 9) Move of Eastside mental health services to Koll Plaza; and 10) Implications of Federal HMO Certification of GHC.

	Measurements*		
1979 OBJECTIVES	P.	R.	O.
Measurement: Total Number of Changes Responded to	8	12	16
b. Assist in the planning, development and coordination of of orientation programs for present and new enrollees.			
Measurement: Number of Programs	4	6	8
c. Provide staff support to the Employee Orientation Task Force to develop a program for employee orientation.			
Measurement: Complete Evaluation of Sound Health Association (SHA) Program	4/79	3/79	2/79
Measurement: Develop Preliminary Plan	4/79	3/79	2/79
Measurement: Plan Completed	10/79	8/79	6/79
d. Revise the Sound Health manual about GHC organization, operation, mission and services for GHC managers to use in their orientation of employees.			
Measurement: Plan Completed	4/79	3/79	2/79
3. Continue to provide the educational diagnosis and program design for patient education programs in response to needs identified by medical staff, management and consumers.			
Measurement: Number of Programs Assisted:	10	13	17
4. Establish an agreement with the medical staff on mechanisms for developing priorities and programs for patient education program.			

	Measurements*		
1979 OBJECTIVES	P.	R.	O.
Measurement: Documented Agreement by	12/79	8/79	6/79
5. Develop and conduct multidisciplinary training sessions on patient teaching skills for GHC providers			
Measurement: Number of Sessions	1	3	6
6. Continue to explore the feasibility, acceptability and safety of self-care programs, by completing the evaluation of the pilot program at Renton Medical Center and developing a design for a second self-care trial in another location.			
Measurement: Renton Medical Center Pilot Completed	12/79	11/79	10/79
Measurement: Second Trial Designed	8/79	6/79	5/79
Measurement: Progress Reports			
1st	8/69	6/79	5/79
2nd	1/80	12/79	11/79
7. Develop the educational plan for the GHC organized system for prevention an health maintenance.			
Measurement: Plan Developed	10/79	7/79	6/79
8. Conduct a feasibility study of a personalized Health Hazard Appraisal system to provide data for panel management and patient education.	(Depending on Funding-$4,700)		
Measurements: Feasibility Study Completed	8/79	7/79	6/79

1979 OBJECTIVES		Measurements*		
		P.	R.	O.
9. Continue and improve group instruction in smoking cessation, food habit management, preparation for childbirth and postpartum and explore alternative educational strategies for persons with special conditions, e.g., planned C-Section delivery, hypertension and multiple health problems.				
Measurement:	Number of Classes*			
	Stop Smoking	160	210	280
	Food Habit Management	160	210	280
	Preparation for Childbirth	1616	1704	2126
	High Risk Pregnancies (Under age 20)	40	48	54
Measurement:	Number of Instructors Monitored	50	75	90
Measurement:	Number of Instructor Inservices	9	11	13
10. Develop specific prenatal education programs in response to consumers' and providers' needs.				
a. Provide C-Section classes to those parents who are planning C-Section deliveries.				
Measurement:	Number of Classes*	100	120	160
b. Provide postpartum parenting classes to women who delivered at GHC.				

---

*Class - 2 hour session (programs are made up of varying number of classes).

1979 OBJECTIVES	Measurements*		
	P.	R.	O.
Measurement: Number of Classes*	126	131	142
c. Provide training opportunities to the prenatal instructors so they will be able to integrate their classes in line with the GHC Fetal Alcohol Program. (Pending GHC approval)			
Measurement: Training Hours	2	4	6
11. Review the prenatal education program in terms of attendance, cost effectiveness and quality of instruction.			
a. Identify non-attenders and develop plans for the involvement of high risk and primiparas.			
Measurement: Plans Completed	10/79	8/79	6/79
b. Develop cost-effective study of GHC prenatal education program.			
Measurement: Study Completed	8/79	6/79	4/79
c. Develop methods of ongoing evaluation of the prenatal instructors in regard to their facilitating skills, empathy, knowledge of content, etc.			
Measurement: Methods will be Implemented	9/79	6/79	4/79
12. Provide staff assistance to the education Council in order to coordinate efforts at GHC.			
Measurement: Number of Hours Contributed (9/month)	130	108	90

---

*Classes - 2 hour session (programs are made up of varying number of classes).

1979 OBJECTIVES	Measurements*		
	P.	R.	O.
13. Continue to provide technical assistance, consultation and staffing upon request to consumers, management, medical staff, individuals or groups, committees and task forces in areas such as:			
1) Selection of educational methods.			
2) Identification of educational resources.			
3) Review and pretest written, audio and/or visual materials.			
Measurement: Hours per Health Education Specialist Allocated	5/mo	10/mo	12/mo
14. Assure the quality and educational effectiveness of pamphlet library items.			
Measurement: Number of Items Reviewed	15/mo	20/mo	25/mo
15. In collaboration with the Employee Relations Department, design and implement a pilot project on employee fitness.			
Measurement: Pilot Designed	11/79	9/79	7/79
Measurement: Pilot Implemented	12/79	10/79	8/79
16. Assure the compatibility of AV equipment purchased at GHC through annual Capital Budget Review.			
Measurement: Review Completed	2/80	12/79	10/79

Sample Forms and Protocols—Educational Protocols

- Cardiac Education Program

Source—Northern California Kaiser Permanente, Oakland, California

CARDIAC EDUCATION PROGRAM

PURPOSE:

This program is aimed at improving the quality of life for each patient involved with it through:

1. Providing the patient and families with an understanding of their disease process.
2. To hasten recovery and reduce the occurrence of complications.
3. To improve patient/family acceptance of limitations resulting from his/her disease.
4. To provide the patient with realistic options so he/she may adjust to his/her illness and regain his/her maximum level of health and independence.

OBJECTIVES:

Knowledge Objectives:

Upon completion of the program, the patient/family should be able to discuss and/or describe knowledge related to cardiac disease and:

1. Anatomy and physiology, injury to the heart, the normal healing process, and their diagnosis.
2. Nutrition—including rationale for diet therapy and modification of eating habits.
3. Drug therapy.
4. Activities of daily living and exercise.
5. Preventive care and reducing the probability of recurrence of the problem.
6. Recognition of complications and the appropriate action to take.

This knowledge can be verified through in-class discussion and feedback.

Skills Objectives:

Upon completion of the program, the patient/family should be able to monitor the patient's pulse rate.

Attitudinal Objectives:

Upon completion of the program, the patient/family should show an understanding of and willingness to become involved in life-style change related to 1) diet; 2) exercise; 3) risk factors; or 4) stress reduction.

Philosophy:

We believe that:

Support of optimal personal integrity demands that each patient has the opportunity to become knowledgeable about his/her own health and disease process and the effects of that disease on his/her life in order that he/she can made wise decisions.

It is the patient's health and well-being that are involved, and that each person (patient) should have the right and responsibility to be actively involved in decisions regarding his/her health care.

Given a general program for all patients, that each individual will also be involved in an individualized learning program with nurses, physicians, and other members of the coronary education team.

The members of the Coronary Education Team should include:

1. The patient/family
2. Inpatient nurses (CCU and medical floor)
3. Physician consultants (staff and home officers)
4. Nutritionists
5. Discharge planning consultant as needed
6. Physical therapy
7. Pharmacist

Concepts/Principles of Learning Which Guide the Coronary Education Program:

1. Learning is personal and individual; it is an internal process; internal synthesis from internal input; learning is active participation; an interaction with one's environment.
2. Learning is developmental; that is, learning builds on prior knowledge; learning is a conceptual process.
3. Learning results in changed behavior.
4. Learning is optimal if done in short segments of time; i.e., there is a limited amount that one can learn at any time; informational bits need to be short.
5. Anxiety also limits the assimilation of information; short teaching sessions may also be more appropriate with anxiety as an interviewing factor in the learning process.

Sample Forms and Protocols—Educational Protocols

- Weight Control Workshop—General Protocol

Source—Adapted From University of Massachusetts/Amherst Health Service and the Valley Health Plan, Amherst, Massachusetts

WEIGHT CONTROL WORKSHOP

General Protocol

I. Goal and Objectives:

To assist participants with an identified weight problem in contributing to their overall health and well-being through modification of eating habits, increase in physical activity where needed, and the creation of a supportive environment for a life style of appropriate nutrition and exercise.

II. Program Operation Objectives:

A. To provide information about:
  1. the importance of a balanced reduction and maintenance diet as a means of weight control
  2. the role of physical activity/exercise in weight control
  3. facilitating weight control through environmental management

B. To create a climate of group support for participants' weight control efforts.

C. To help participants gain insight into the psychosocial aspects of their weight problems, such as self image, failure experiences, psychological barriers to weight loss, etc.

D. To help participants develop individualized weight reduction/control plans.

E. To encourage the incorporation of improved weight-related habits into long term lifestyle.

F. To affirm each individual's acceptance of responsibility for working toward his/her weight-related goals.

Participants' objectives will, and should, vary. Participants will have an opportunity to delineate their own expectations, and the curriculum should be flexible enough to accommodate individual needs as appropriate in the context of a group workshop. The impact objectives obviously relate to weight reduction and maintenance over time. The weight goals will vary among participants.

III. Fees:

Group approach emphasizes the integration of dietary and behavioral weight control concepts necessary for long-term maintenance. It is important that a commitment to this group be made at the very beginning, both for personal success and in order to provide support to others. To affirm this commitment, a small fee will be necessary for membership, a portion of which will be returned to the participant upon completion of the program.

IV. Medical Clearance:

Shall be obtained when the protocol is approved by the Clinical Practices Committee.

V. Facilitator Qualifications:

Minimal demonstrated competencies will include:

A. Group process skills
B. Basic nutrition and exercise facts
C. Basic awareness of the psychosocial aspects of weight problems
D. Knowledge and experience with environmental management and behavioral modification techniques
E. Program planning skills, including utilization of appropriate specialist personnel

VI. Curriculum:

Should be flexible, but should incorporate necessary group principles as well as specific content issues. Possibilities include:

—Group discussion of previous weight reduction trials
—Psycho-social issues, e.g., attitudes of self and others toward obesity
—Principles of weight reduction/control
—The role of good nutrition in weight control
—Setting realistic goals
—Binge eating
—Working with the exchanges and diet pattern
—Exercise management: its value in weight control and good health
—Introduction of environmental management and its role in weight reduction; analysis of environmental stimuli
—The Behavior Chain (Ferguson: Habits, Not Diets) and alternative activities
—Nutrition as a preventative factor: its contribution to long-range health maintenance—rewards for success
—Coping with special occasions
—Food facts and fallacies
—Rewards for goal achievement and behavior change

—Identification of other sources of support; group disengagement
—Specific time set aside at each session for weighing in and discussion of participants' concerns

VII. Participant Requirements:

A. Attendance (1 excused absence permitted)
B. Completion of all required forms and reports (see VIII A)
C. Participants in weight control workshops will have an identified weight problem of 15—20 pounds over ideal weight. Participants in workshops for the marginally overweight will have an identified weight problem of less than 15 pounds over ideal weight.

VIII. Data Collection and Evaluation:

A. Required:
  1. Before or during workshop—previous weight reduction experience
     —behavior oriented food intake monitoring sheets
     —exercise monitor sheets
     —weigh-in figures
     —post-workshop participant feedback evaluation
  2. Follow-up of program dropouts
  3. Three month follow-up on designated indicators
  4. One year follow-up
B. Optional
  1. Individual consultation
  2. Daily journals
  3. Attitude questionnaires
  4. 3-12 month follow-up of drop-outs
C. Content: evaluation shall consider weight, energy intake, environmental factors, attitudes, goals, and other behaviors. The basic standard questions must be used by all facilitators although each can modify the form by asking for additional information.

IX. Health Record Documentation:

A notation shall be made by the facilitator noting attendance, weight, special concerns, etc. in the health record; participation and progress will also be recorded on the problem list.

X. Accountability

A. Facilitator qualifications and performance will be reviewed by Division Directors as part of the professional staff review process.

B. Proposals should be submitted to Division Directors at least one month in advance.
C. Reports, which include the required information outlined in Section VIII will be required of all weight group facilitators.
D. All weight control workshops are coordinated and reviewed by the Director of Health Education.

Sample Forms and Protocols—Educational Protocols
- Vasectomy Outline

Source—Family Health Program, Long Beach, California

VASECTOMY OUTLINE

I. Receptionist calls MRR for cost, puts amount and initials of MRR on VIF.

II. Vasectomy information form completed

III. Assess Patient
  A. Reason
  B. Number of children
  C. Age
  D. Marital status—wife's opinion
  E. Situation of spouse or children
    1) Death of spouse or children
    2) Divorce

IV. Other Forms of Birth Control

  A. Pill
  B. IUD
  C. Diaphragm
  D. Condom
  E. Foam
  F. Natural

V. Film on Vasectomy

VI. Pre-Operation

  A. Pre-op shave
  B. Bring someone to drive
  C. Wear an athletic supporter-not jockey shorts

VII. Operation

- A. Incision—metal clamp
- B. Local anesthesia
- C. Ten minutes for operation
- D. Santa Ana, Tuesday afternoons

VIII. Post-Operation

- A. Use ice pack continuously
- B. Sperm count 6 weeks (OR NOT STERILE) or 12 ejaculations test needs to be repeated until 0 sperm present
- C. Complications
  - 1) Swelling or bleeding
- D. No effect on sexuality

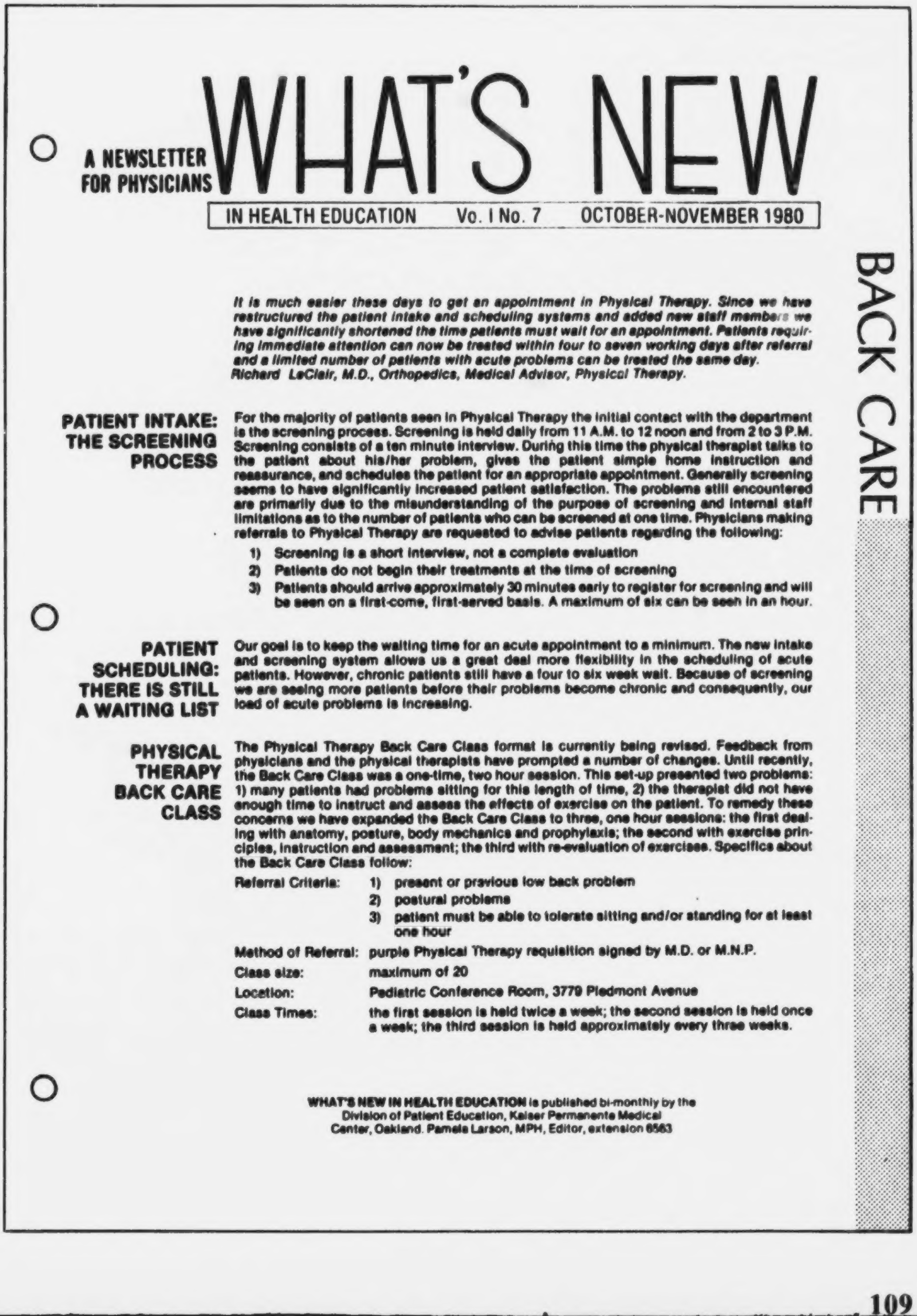
Paperwork Follow-Up

- A. Patient
  - 1) Book
  - 2) Vasectomy instructions and appointment card
  - 3) Explain fee
- B. Dr. Pritzl nurse
  - 1) Signed consent and surgery date
- C. Appointment Desk
  - 1) Surgery date
- D. Health Education Files
  - 1) Vasectomy information form
  - 2) Signed consent

Sample Forms and Protocols—Physician Newsletter

- What's New in Health Education—A Newsletter for Physicians

Source—Kaiser-Permanente Medical Care Center, Oakland, California



A NEWSLETTER FOR PHYSICIANS

WHAT'S NEW

IN HEALTH EDUCATION Vo. I No. 7 OCTOBER-NOVEMBER 1980

BACK CARE

It is much easier these days to get an appointment in Physical Therapy. Since we have restructured the patient intake and scheduling systems and added new staff members we have significantly shortened the time patients must wait for an appointment. Patients requiring immediate attention can now be treated within four to seven working days after referral and a limited number of patients with acute problems can be treated the same day.
Richard LeClair, M.D., Orthopedics, Medical Advisor, Physical Therapy.

PATIENT INTAKE: THE SCREENING PROCESS

For the majority of patients seen in Physical Therapy the initial contact with the department is the screening process. Screening is held daily from 11 A.M. to 12 noon and from 2 to 3 P.M. Screening consists of a ten minute interview. During this time the physical therapist talks to the patient about his/her problem, gives the patient simple home instruction and reassurance, and schedules the patient for an appropriate appointment. Generally screening seems to have significantly increased patient satisfaction. The problems still encountered are primarily due to the misunderstanding of the purpose of screening and internal staff limitations as to the number of patients who can be screened at one time. Physicians making referrals to Physical Therapy are requested to advise patients regarding the following:

1) Screening is a short interview, not a complete evaluation
2) Patients do not begin their treatments at the time of screening
3) Patients should arrive approximately 30 minutes early to register for screening and will be seen on a first-come, first-served basis. A maximum of six can be seen in an hour.

PATIENT SCHEDULING: THERE IS STILL A WAITING LIST

Our goal is to keep the waiting time for an acute appointment to a minimum. The new intake and screening system allows us a great deal more flexibility in the scheduling of acute patients. However, chronic patients still have a four to six week wait. Because of screening we are seeing more patients before their problems become chronic and consequently, our load of acute problems is increasing.

PHYSICAL THERAPY BACK CARE CLASS

The Physical Therapy Back Care Class format is currently being revised. Feedback from physicians and the physical therapists have prompted a number of changes. Until recently, the Back Care Class was a one-time, two hour session. This set-up presented two problems: 1) many patients had problems sitting for this length of time, 2) the therapist did not have enough time to instruct and assess the effects of exercise on the patient. To remedy these concerns we have expanded the Back Care Class to three, one hour sessions: the first dealing with anatomy, posture, body mechanics and prophylaxis; the second with exercise principles, instruction and assessment; the third with re-evaluation of exercises. Specifics about the Back Care Class follow:

Referral Criteria:
1) present or previous low back problem
2) postural problems
3) patient must be able to tolerate sitting and/or standing for at least one hour

Method of Referral: purple Physical Therapy requisition signed by M.D. or M.N.P.

Class size: maximum of 20

Location: Pediatric Conference Room, 3779 Piedmont Avenue

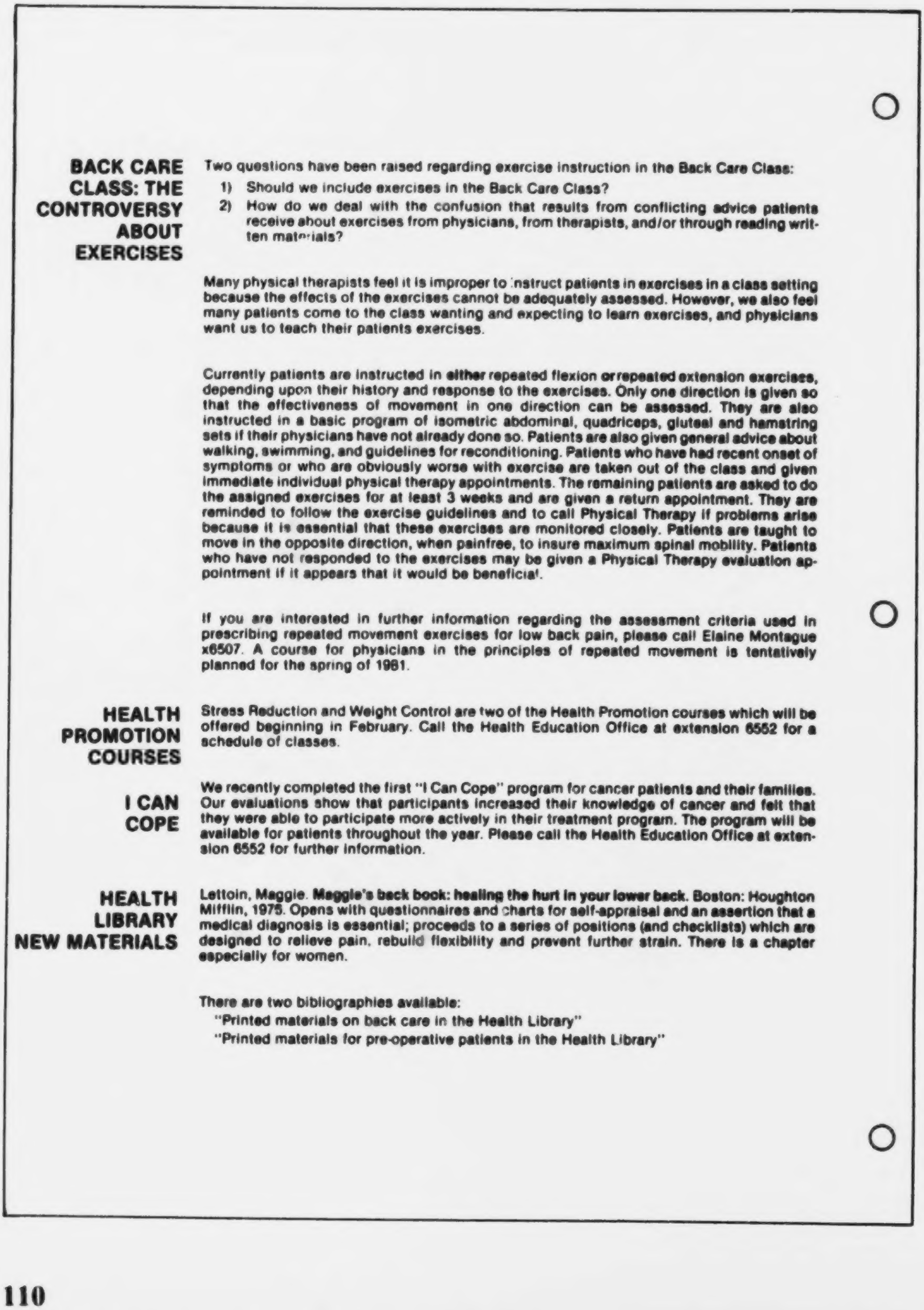
Class Times: the first session is held twice a week; the second session is held once a week; the third session is held approximately every three weeks.

WHAT'S NEW IN HEALTH EDUCATION is published bi-monthly by the
Division of Patient Education, Kaiser Permanente Medical
Center, Oakland. Pamela Larson, MPH, Editor, extension 6563

Sample Forms and Protocols—Physician Newsletter (Continued)

- What's New in Health Education—A Newsletter for Physicians

Source—Kaiser-Permanente Medical Care Center, Oakland, California



BACK CARE CLASS: THE CONTROVERSY ABOUT EXERCISES

Two questions have been raised regarding exercise instruction in the Back Care Class:

1) Should we include exercises in the Back Care Class?
2) How do we deal with the confusion that results from conflicting advice patients receive about exercises from physicians, from therapists, and/or through reading written materials?

Many physical therapists feel it is improper to instruct patients in exercises in a class setting because the effects of the exercises cannot be adequately assessed. However, we also feel many patients come to the class wanting and expecting to learn exercises, and physicians want us to teach their patients exercises.

Currently patients are instructed in **either** repeated flexion **or** repeated extension exercises, depending upon their history and response to the exercises. Only one direction is given so that the effectiveness of movement in one direction can be assessed. They are also instructed in a basic program of isometric abdominal, quadriceps, gluteal and hamstring sets if their physicians have not already done so. Patients are also given general advice about walking, swimming, and guidelines for reconditioning. Patients who have had recent onset of symptoms or who are obviously worse with exercise are taken out of the class and given immediate individual physical therapy appointments. The remaining patients are asked to do the assigned exercises for at least 3 weeks and are given a return appointment. They are reminded to follow the exercise guidelines and to call Physical Therapy if problems arise because it is essential that these exercises are monitored closely. Patients are taught to move in the opposite direction, when painfree, to insure maximum spinal mobility. Patients who have not responded to the exercises may be given a Physical Therapy evaluation appointment if it appears that it would be beneficial.

If you are interested in further information regarding the assessment criteria used in prescribing repeated movement exercises for low back pain, please call Elaine Montague x6507. A course for physicians in the principles of repeated movement is tentatively planned for the spring of 1981.

HEALTH PROMOTION COURSES

Stress Reduction and Weight Control are two of the Health Promotion courses which will be offered beginning in February. Call the Health Education Office at extension 6552 for a schedule of classes.

I CAN COPE

We recently completed the first "I Can Cope" program for cancer patients and their families. Our evaluations show that participants increased their knowledge of cancer and felt that they were able to participate more actively in their treatment program. The program will be available for patients throughout the year. Please call the Health Education Office at extension 6552 for further information.

HEALTH LIBRARY NEW MATERIALS

Lettoin, Maggie. **Maggie's back book: healing the hurt in your lower back.** Boston: Houghton Mifflin, 1976. Opens with questionnaires and charts for self-appraisal and an assertion that a medical diagnosis is essential; proceeds to a series of positions (and checklists) which are designed to relieve pain, rebuild flexibility and prevent further strain. There is a chapter especially for women.

There are two bibliographies available:
"Printed materials on back care in the Health Library"
"Printed materials for pre-operative patients in the Health Library"

Sample Forms and Protocols—Position Descriptions
- Director of Health Education

Source—Genessee Valley Group Health Association, Rochester, New York

GENESEE VALLEY GROUP HEALTH ASSOCIATION—WILSON HEALTH CENTER

TITLE: Director of Health Education, Health Education Specialist
QUALIFICATIONS: Master's Degree in Public Health (M.P.H.) with experience as a health educator in a health care delivery setting

Specific duties and responsibilities:

1) Identify health education needs and priorities according to overall goals and objectives of Group Health (Wilson Health Center). Develop an educational diagnosis in each of the priority areas.
2) Coordinate the planning, implementation, and evaluation of all health education programs throughout the Health Center.
3) Provide leadership in the utilization of education concepts, methods, and materials and serve as a resource in health education to the Health Center staff and the community.
4) Develop and maintain communication ties throughout the Health Center, GVGHA and particularly the Medical Group. Coordinate the Medical Group information portion of the Newsletter and write articles for the Medical Group.
5) Develop objectives and a budget for the department each year.
6) Attend Chiefs of Service Committee and report on health education activities to that group.
7) Serve as a program instructor/group facilitator for various health education programs (i.e., Smoking Cessation, Managing Stress, etc.).
8) Develop a referral mechanism for use by the Medical Group to education programs and audiovisual services.
9) Develop a system of communication to the providers regarding the educational experiences of his/her patients.
10) Develop innovative approaches to reach high risk populations.
11) Develop innovative health education programs with follow-up and evaluation mechanisms.
12) Plan, develop, and evaluate inservice education programs with various levels of staff.
13) Plan, develop, and evaluate orientation programs for Medical

Group staff and function as a consultant in planning new member orientation.

14) Provide educational consultation to various departments, committees, grant projects, and prevention programs.
15) Chair or co-chair the following committees in addition to coordinating the staff work for the committees:
    a. Early Detection Committee
    b. Health Education Advisory Committee
    c. Providers of Group Education Committee
    d. Health Assessment Committee
16) Supervise the activities of the Health Education Assistant.
17) Provide consultation and overall direction in the purchase and use of audiovisual equipment throughout the center.
18) Supervise the field experience of students of all disciplines who wish to be involved in health education programs. Integrate the student experiences into overall Health Center goals and objectives.

Sample Forms and Protocols—Position Descriptions
- Health Educator

Source—Northern California Kaiser-Permanente Medical Care Program Oakland, California

NORTHERN CALIFORNIA KAISER-PERMANENTE MEDICAL CARE PROGRAM

Health Educator

FUNCTIONS: Under the direction of the local Division Chief of Patient Education, and the administrative team, the health educator will:

1. Gather data regarding the health status of the Kaiser Permanente members within a defined service area, with attention given to physiological, psycho-social, cultural and cognitive factors which affect the level of members' health.
2. Record aspects of specific health problems of the member population, identifying behaviors implicated in the etiology of the health problems.
3. Identify the factors (member, family or health professional opinions, beliefs, and values; social norms; social support systems; economic, governmental, political...which need strengthening, eliminating, or modifying in order to support a voluntary change in member health behavior.

4. Meet regularly with the local Patient Education Committee, Chiefs of Services, Department Heads, and other decision makers to gain perspective on member utilization problems and member health status problems.
5. Select, through priority development, the health behaviors most amenable to change through educational services.
6. Work closely with the staff or related medical departments as well as nursing and other allied health services regarding available commitment, staffing, and resources to provide targeted educational services for members.
7. Train designated KPMC staff to select and implement appropriate educational processes to help members generate valid information, explore options and their consequences, choose freely and commit themselves to actions which will maintain or improve their health.
8. Survey and catalogue health and patient education services offered to KPMC members by the medical center, including services offered in KPMC inpatient, outpatient, rehabilitation, home health and hospice sites.
9. Assist instructors in the development of program objectives, selection of educational methods and materials, improvement critique of teaching style, preparation of a budget, documentation of productivity, and documentation of outcomes.
10. Survey and catalogue health and patient education services available to KPMC members by agencies, institutions and organizations in the community.
11 Maintain effective communication and a strong consultant relationship to all of the departments in the medical center in matters pertaining to member health and patient education.
12. Participate in decision-making; set work priorities; participate in long range goal setting for health and patient education activities.
13. Maintain health education spending within KFH Community Service budget constraints.
14. Prepare reports on health and patient education activities throughout the medical center.
15. Provide consultation and staff development programs on educational diagnosis, educational methods, and rudimentary evaluation techniques.
16. Be a role model by skillfully using group processes in combination with a variety of other educational methods in meetings, training programs, and programs for members.
17. Provide a wide variety of examples of high quality protocols, and written standards for the delivery of health and patient education programs.
18. Provide protocols for the review of educational materials (pamphlets, audiovisuals, posters, etc.) prior to purchase by departments.

19. Take responsibility for continued professional development in health education—especially in the areas of health education diagnosis, planning, implementation and evaluation, and health education management. Additional training in behavioral sciences, especially in health behavior change is recommended.
20. Prepare case study reports on programs; prepare newspaper articles, brochures, feature stories, materials for radio and television and preliminary drafts of Annual Reports.

Salary Grade: 11

Minimum Education and Experience Required: A college degree plus several years' experience conducting health and patient education programs in medical care settings; and currently in formal graduate training in health education or good faith desire to enter training within two years.

Sample Forms and Protocols—Position Descriptions
- Health Education Coordinator

Source—Northern California Kaiser-Permanente Medical Care Program, Oakland, California

NORTHERN CALIFORNIA KAISER-PERMANENTE MEDICAL CARE PROGRAM

Health Education Coordinator

FUNCTIONS: Under the direction of the local Division Chief of Patient Education, and the administrative team, the health educator will:

1. Meet the requirements for the functions of Health Educator (see attached) and in addition will:
2. Design health education interventions, including a plan describing the educational diagnosis, objectives, targeted behaviors, recommended methods, documentation, and evaluation regarding costs and outcomes, for health and patient education services.
3. Prepare health education protocols, using the systematic application of health education theory and health behavior change theory.
4. Analyze behavioral theory and empirical evidence from health and patient education research in order to make interpretations

relevant to the practice of health and patient education at the medical center.

5. Rate the relative importance of different factors influencing health behaviors in terms of:
    a. strength of their association with the behavior;
    b. potential of each for change through voluntary processes.
6. Analyze and interpret scientific evidence in order to participate in policy formulation or to recommend policy for local health and patient education programs.
7. Interpret regional policy and take responsibility for its application to health and patient education practice at the local level.
8. Help the organization meet its responsibility for accountability and interpret benefits achieved by health education programs.
9. Set short and long range goals and objectives for health education development.
10. Manage medical center-wide health and patient education activities and supervise health education personnel.
11. Prepare proposals and contracts for funding health education activities; manage and evaluate health education grants.
12. Prepare professional reports and articles for journals.
13. Design health and patient education programs so that evaluative measures are built into them.
14. Design and manage process and outcome evaluation of health and patient education programs and activities; design and manage action research and cost benefit analysis, where appropriate.
15. Design and conduct studies on health related behavior, health education methods, and behavior change problems.
16. Keep abreast of local, state and federal legislation and policy relative to health and patient education.
17. Design continuing education and relevant training programs for health education manpower development, and for other health personnel.
18. Design and manage consultation related to health and patient education activities within the medical center.
19. Design and manage the use of health information methods and audiovisual resources needed to complement a health education program; information methods and audiovisual resources needed to complement a health education program; inform instructors of their potential and limitations.
20. Understand appropriate applications of computer technology for planning, conducting and evaluating educational activities.
21. Use scientific and scholarly inquiry to advance professional knowledge and improve standards of practice.
22. Anticipate health education needs in a rapidly changing society and project ethical, innovative ways to meet those needs.

Salary Grade: 13

Minimum Education and Experience Required: MPH, MA, MS or MEd in Health Education and two to three years' work experience in a medical care setting (hospitals and clinics), or,

BA, BS in Health Education and at least five years' experience as a health educator in a medical care setting.

Sample Forms and Protocols—Position Descriptions

- Director of Health Education and Staff Development

Source—INA Healthplan of California

Director of Health Education and Staff Development

DEPARTMENT: Health Education/Staff Development

POSITION PURPOSE: Health Education: To provide a conprehensive program of health education services for INA Healthplan of California enrollees based on organizational priorities of our members including diet and non-dietary health education programs and materials.

DIMENSIONS: Personnel: Five and one half (5 1/2)
Department Payroll: $124 M/Yearly minimum
Department Budget: $ 68 M/Yearly minimum
Recipients of Services: All enrollees of INA Healthplan of California (approximately 130,000)

REPORTS TO: Vice President of Administrative Services

AS DO: Director of Human Resources
Director of Professional Placement
Director of Communication
Director of Purchasing
Director of Construction and Maintenance

POSITIONS REPORTING DIRECTLY TO THIS POSITION:
Manager of Clinical Nutrition
Health Education Coordinator
Department Secretary: 50% time in health education

POSITION SUMMARY:
This position directs the planning, development and implementation of Health Education services available to INA Healthplan of California enrollees.

Plans —With the assistance of Medical Chiefs of Service, Regional Medical Directors and Department Staff, plans all health education programs.

Researches —This position researches the clinical and health education methodological aspects of each priority health related topic to assure accuracy and effectiveness of program content and method of delivery. Administers all outside funded investigative research into program effectiveness.

Budgets —Annually projects the payroll, capital and other operating expenditures for the health education department.

Develops —With the assistance of appropriate physicians, out of house experts and department staff, develops all clinical and audio-visual program content and health education related printed material including the *Health Informagrams*.

Prioritizes —With the assistance of Regional Medical Directors, Chiefs of Staff and staff physicians, defines organizational health education priorities.

Directs —This position directs the support staff to accomplish the above.

Facilitates —This position facilitates the training of personnel outside the Health Education Department to conduct health education programs, develop and provide materials including audio-visuals and printed handouts used in such programs. Such personnel includes nurse practitioners and other nursing staff. Central administrative records are kept of patient encounters incorporated in these as well as all departmentally conducted programs.

HEALTH EDUCATION RESPONSIBILITIES

SPECIFIC TYPES OF KNOWLEDGE, SKILL AND EXPERIENCE REQUIRED FOR THE POSITION:

The incumbent must have a strong background in the biological sciences. This person must have demonstrated excellence in written and verbal communication as well as in program development and implementation in health education. Formal academic training, at the master's level in health education and at least two years of experience in directing health education activities with supervisory and budgeting responsibilities are highly recommended. The person must project a positive role model consistent with the objectives of health education and facilitating credibility in dealing with physicians and other professionals in the health care industry. Must be trained in research methodology so as to be able to conduct independent investigations into program effectiveness.

DIFFICULT AND COMPLEX PROBLEMS:

— Given the physical plant differences among health care centers and demographic differences among enrollees served, the greatest challenge is to develop a standardized scope of services available to all members.

- Periodically, obstructionism is encountered in the health care centers that generates from the ancillary personnel with regard to cooperation in scheduling patients, seeing health education staff, pulling charts.
- Limited staff results in much time in travel between facilities that could be used in counseling.

MAJOR PROBLEMS NORMALLY REFERRED TO SUPERVISOR OR OTHERS:
Approval of all purchase orders and check requests beyond scope of authorization.

PRINCIPAL ACCOUNTABILITIES:

1. Provide INA Healthplan enrollees with financially and clinically relevant health education programs and services.
2. Standardize the quality, content and method of implementation of all available health education services.
3. Assess the needs and priorities for health education services and programs among enrollee and develop services and programs in accordance with these priorities.
4. Hire, orient and assign to designated regions, health education coordinators and dietitians competent in the delivery of specified health education programs.
5. Provide ongoing training for staff in skills needed to expand and improve the scope and quality of health education services.

(PART 2)

POSITION TITLE: Director of Health Education and Staff Development

DEPARTMENT: Health Education/Staff Development

POSITION PURPOSE: Staff Development: To provide a comprehensive program of staff development and training programs to INA Healthplan of California employees based on organizational priorities.

DIMENSIONS: Personnel: one and one half (1 1/2)
Department Payroll: $50 M/Yearly minimum
Department Budget: $59 M/Yearly minimum

REPORTS TO: Vice President of Administrative Services

AS DO: Director of Human Resources
Director of Professional Placement
Director of Communication
Director of Purchasing
Director of Construction and Maintenance

POSITIONS REPORTING DIRECTLY TO THIS POSITION:
Training Specialist
Department secretary: 50% time in staff development

POSITION SUMMARY:
This position directs the planning, development and implementation as well as the coordination of all in-house and designated out-of-house training programs for INA Healthplan of California employees, with the exception of marketing.
Plans — With assistance of appropriate personnel plans all in-house training programs (with the exception of marketing), with company-wide impact.
Researches — This position researches or directs the research of materials and content to be included in all internally conducted in-house training programs with company-wide impact (except marketing.)
Budgets — Annually projects the payroll, capital and other operating expenditures for the staff development department.
Develops — With the assistance of appropriate personnel, develops content and selects and/or develops audio-visuals (handouts, films, exercises) for all internally conducted in-house training programs with company-wide impact.
Prioritizes — With the assistance of the appropriate personnel, defines staff development priorities for INA Healthplan of California.
Directs — This position directs the support staff to accomplish the above.
Coordinates — This position coordinates all in-house and out-of-house training programs conducted by outside resources as well as those conducted by in-house personnel.
Trains — This position provides direct training to INA Healthplan employees on designated topics.

STAFF DEVELOPMENT RESPONSIBILITIES:

SPECIFIC TYPES OF KNOWLEDGE, SKILL AND EXPERIENCE REQUIRED FOR THIS POSITION:
The incumbent must have a strong background in adult education and learning theory. This person must have demonstrated excellence in written and verbal communication as well as in program development and implementation in staff development, including orientations, supervisory training and manual development. Formal academic training

at the master's level in the education field and two years of experience in directing staff development activities with supervisory and budgeting responsibilities are highly recommended. The person must project a positive role model consistent with the objectives of organizational development and facilitating credibility in dealing with administration.

DIFFICULT AND COMPLEX PROBLEMS:

- Geographical spread among the health care centers impairs the opportunity to conduct centralized training programs.
- Limitations in policies and procedures required as a core for manuals and training topic substance impairs the development and implementation of priority training programs, e.g., equal employment opportunities, wage and salary administration.
- Limited internal manpower resources impair participation of internal experts in training in their areas of expertise, e.g., budgeting.

MAJOR PROBLEMS NORMALLY REFERRED TO SUPERVISOR OR OTHERS:

Approval of all purchase orders and check requests beyond scope of authorization. Sensitive areas such as policy discrepancies among the health care centers, e.g., requirement for certification in venapuncture, I.V. therapy. Proposals for perceived staff development related policy and program priorities.

PRINCIPAL ACCOUNTABILITIES:

1. Provide INA Healthplan enrollees with financially and operationally relevant staff development programs including tuition assistance, continuing education, supervisory training and orientations.
2. Assess the needs and priorities for staff development services and programs among the staff and administration.
3. Develop and direct the development of operationally relevant manuals of operation in designated functional areas.
4. Hire, orient and assign to designated responsibilities, staff competent in the delivery of specified staff development programs and services.
5. Coordinate in- and out-of-house training programs conducted by internal as well as external training resources.
6. Propose staff development related policies and procedures consistent with the organizational priorities.

Sample Forms and Protocols—Position Descriptions

- Director of Health Education

Source—General Medical Centers, Anaheim, California

Director of Health Education

DEPARTMENT: Health Education

IMMEDIATE SUPERVISOR'S TITLE: Associate Medical Director

RESPONSIBLITIES: Coordination and administration of all health education activities to include patient education, enrollee health education, and staff training when appropriate. Works closely with administrative and patient care staff to mobilize in-house and community resources.

SPECIAL TRAINING REQUIRED: M.P.H. with specialization in Health Education and experience in the development of health education programs in community and clinical settings. Must possess skills in program planning, community organizing, evaluation, counseling, and communication. Familiarity with HMOs is highly desirable.

SPECIFIC DUTIES:

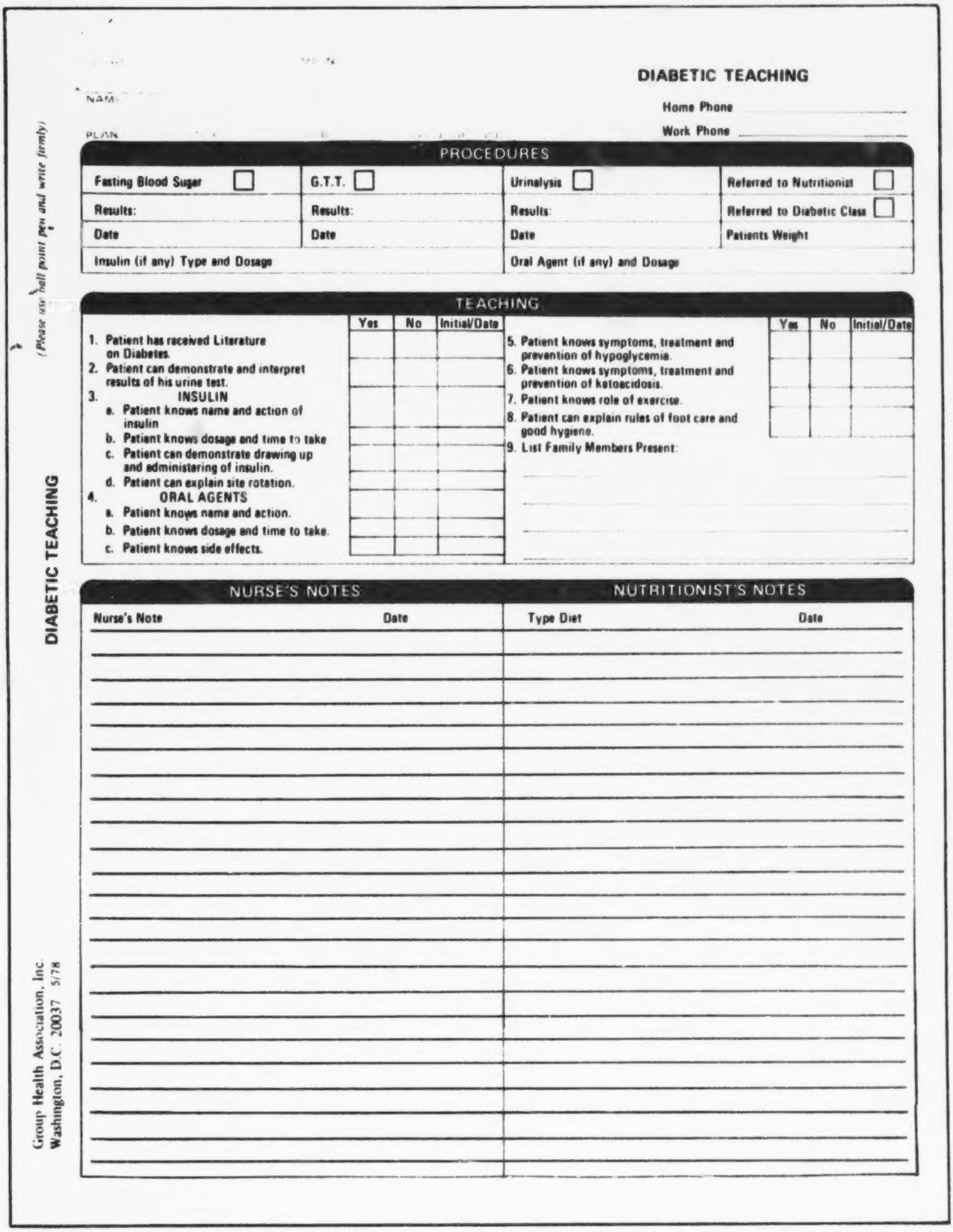
1. Review and select patient education literature.
2. Develop, organize, implement, and evaluate health education classes for members in such areas as prenatal care, hypertension, weight control, and family planning.
3. Organize and teach CPR classes for all clinic personnel and consumers.
4. Work with Service Representative in Marketing to establish contact with commercial accounts to develop health education programs for consumers and potential consumers.
5. Review and select audio-visual teaching aids.
6. Develop patient education literature.
7. Write health education articles for member newsletter/magazine.
8. Counsel patients upon physician referral in areas of hypertension, diabetes, weight control, nutrition, birth control, and relaxation.
9. Act as resource for nursing staff in matters related to patient education.
10. Organize and conduct in-serviced training for nursing staff related to education content and methodology.

AND OTHER DUTIES AS MAY BE ASSIGNED BY THE SUPERVISOR.

Sample Forms and Protocols—Medical Record Forms

- Diabetic Teaching

Source—Group Health Association, Washington, D.C.



NAME

PLAN

DIABETIC TEACHING

Home Phone ______________

Work Phone ______________

(Please use ball point pen and write firmly)

PROCEDURES

Fasting Blood Sugar ☐	G.T.T. ☐	Urinalysis ☐	Referred to Nutritionist ☐
Results:	Results:	Results:	Referred to Diabetic Class ☐
Date	Date	Date	Patients Weight
Insulin (if any) Type and Dosage		Oral Agent (if any) and Dosage	

TEACHING

	Yes	No	Initial/Date
1. Patient has received Literature on Diabetes.			
2. Patient can demonstrate and interpret results of his urine test.			
3. INSULIN			
a. Patient knows name and action of insulin			
b. Patient knows dosage and time to take			
c. Patient can demonstrate drawing up and administering of insulin.			
d. Patient can explain site rotation.			
4. ORAL AGENTS			
a. Patient knows name and action.			
b. Patient knows dosage and time to take.			
c. Patient knows side effects.			

	Yes	No	Initial/Date
5. Patient knows symptoms, treatment and prevention of hypoglycemia.			
6. Patient knows symptoms, treatment and prevention of ketoacidosis.			
7. Patient knows role of exercise.			
8. Patient can explain rules of foot care and good hygiene.			

9. List Family Members Present: ______________

NURSE'S NOTES | NUTRITIONIST'S NOTES

Nurse's Note	Date	Type Diet	Date

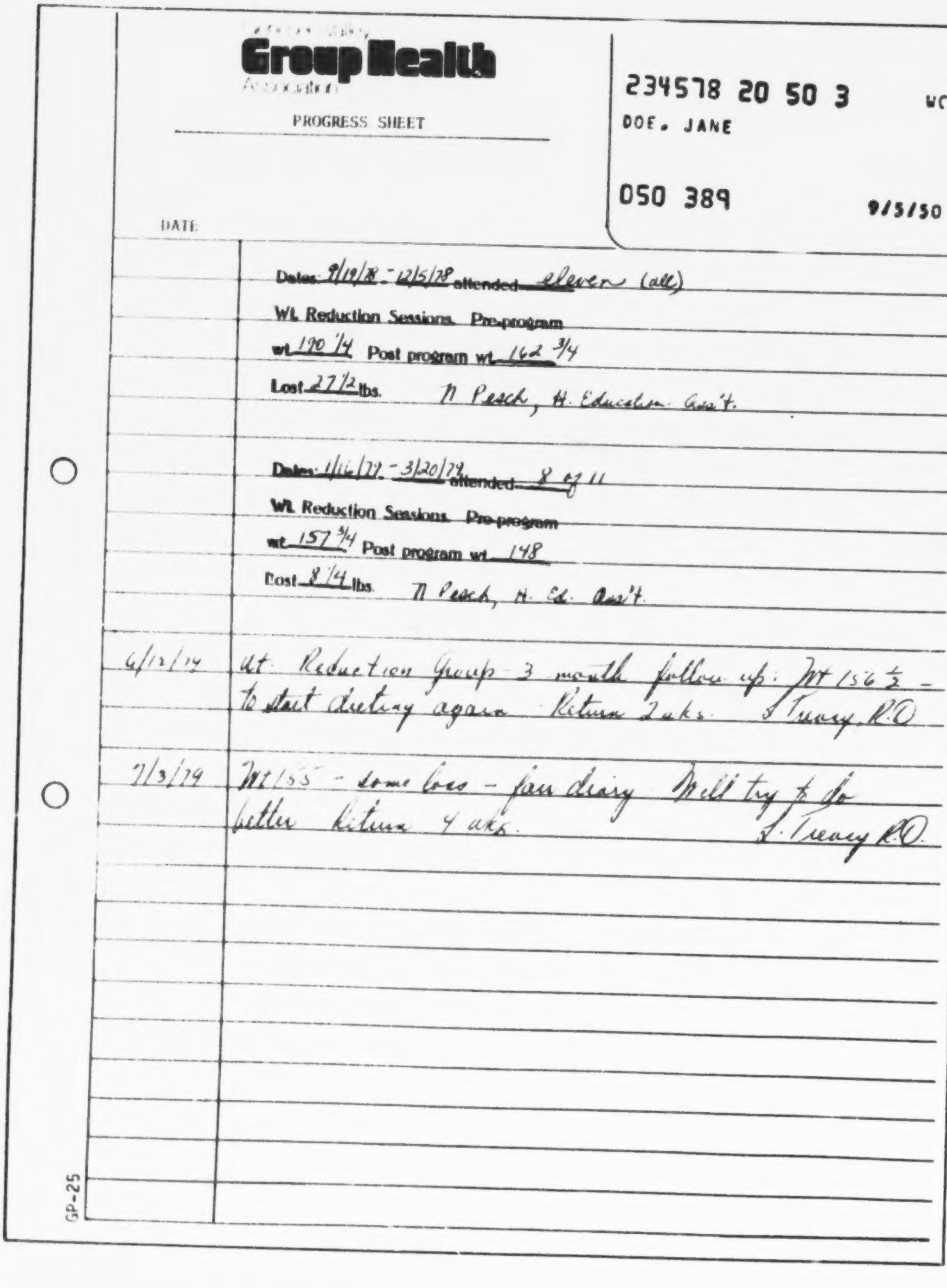
DIABETIC TEACHING

Group Health Association, Inc.
Washington, D.C. 20037 5/78

Sample Forms and Protocols—Medical Record Forms

- Record Stamp

Source—Genessee Valley Health Association, Rochester, New York



Genesee Valley
Group Health
Association

PROGRESS SHEET

234578 20 50 3 WC
DOE, JANE

050 389 9/5/50

DATE

Dates 9/19/78 - 12/5/78 attended eleven (all)
Wt. Reduction Sessions. Pre-program
wt 190 1/4 Post program wt 162 3/4
Lost 27 1/2 lbs. N Pesch, H. Education Ass't.

Dates 1/16/79 - 3/20/79 attended 8 of 11
Wt. Reduction Sessions. Pre-program
wt 157 3/4 Post program wt 148
Lost 8 1/4 lbs. N Pesch, H. Ed. Ass't.

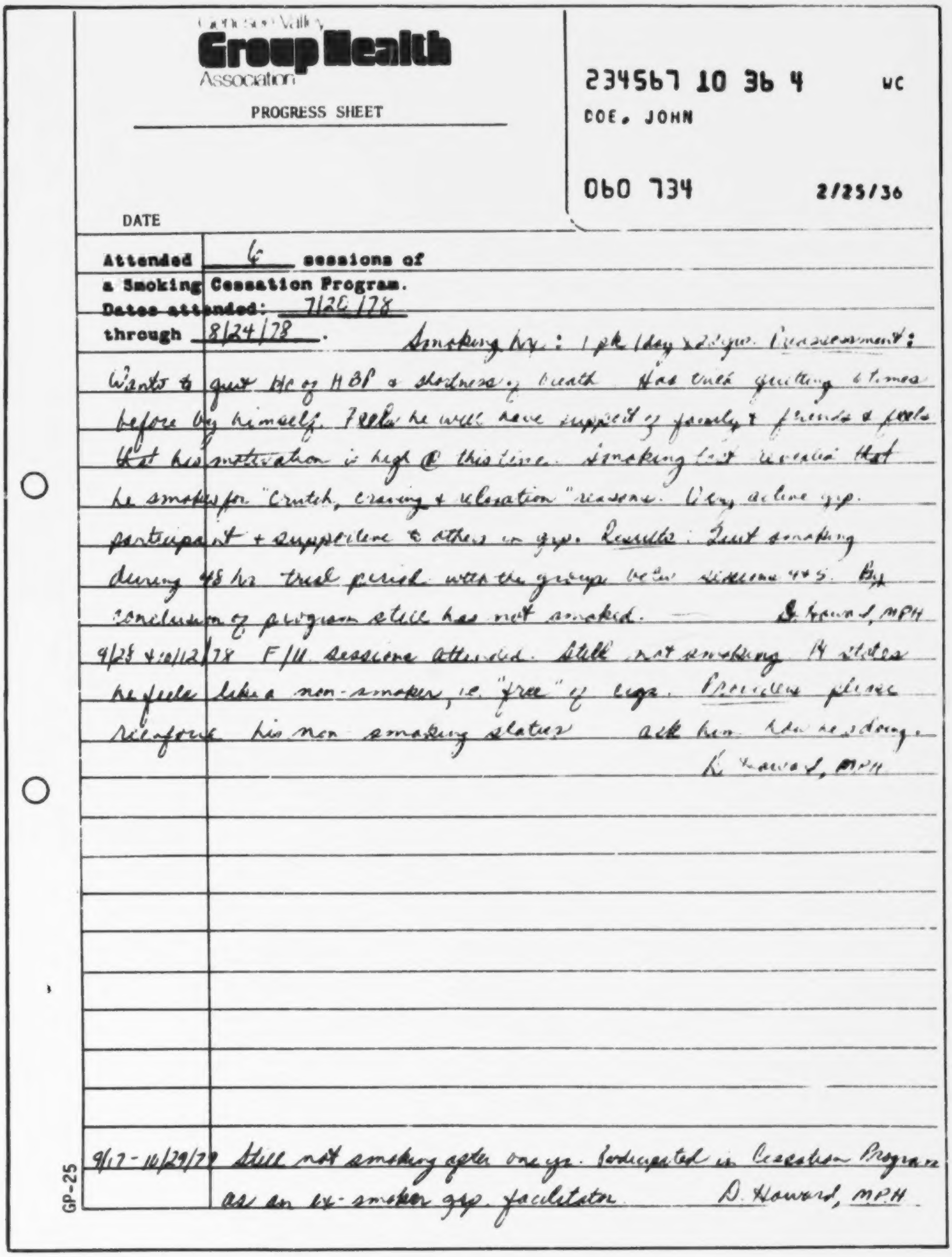
6/12/79 Wt. Reduction Group 3 month follow up: Wt 156 1/2 - to start dieting again. Return 2 wks. S. Treacy R.D.

7/3/79 Wt 155 - some loss - fair diary. Will try to do better. Return 4 wks. S. Treacy R.D.

GP-25

Sample Forms and Protocols—Medical Record Forms (Continued)
- Record Stamp

Source—Genessee Valley Health Association, Rochester, New York



Genesee Valley
Group Health
Association

PROGRESS SHEET

234567 10 36 4 WC
DOE, JOHN

060 734 2/25/36

DATE

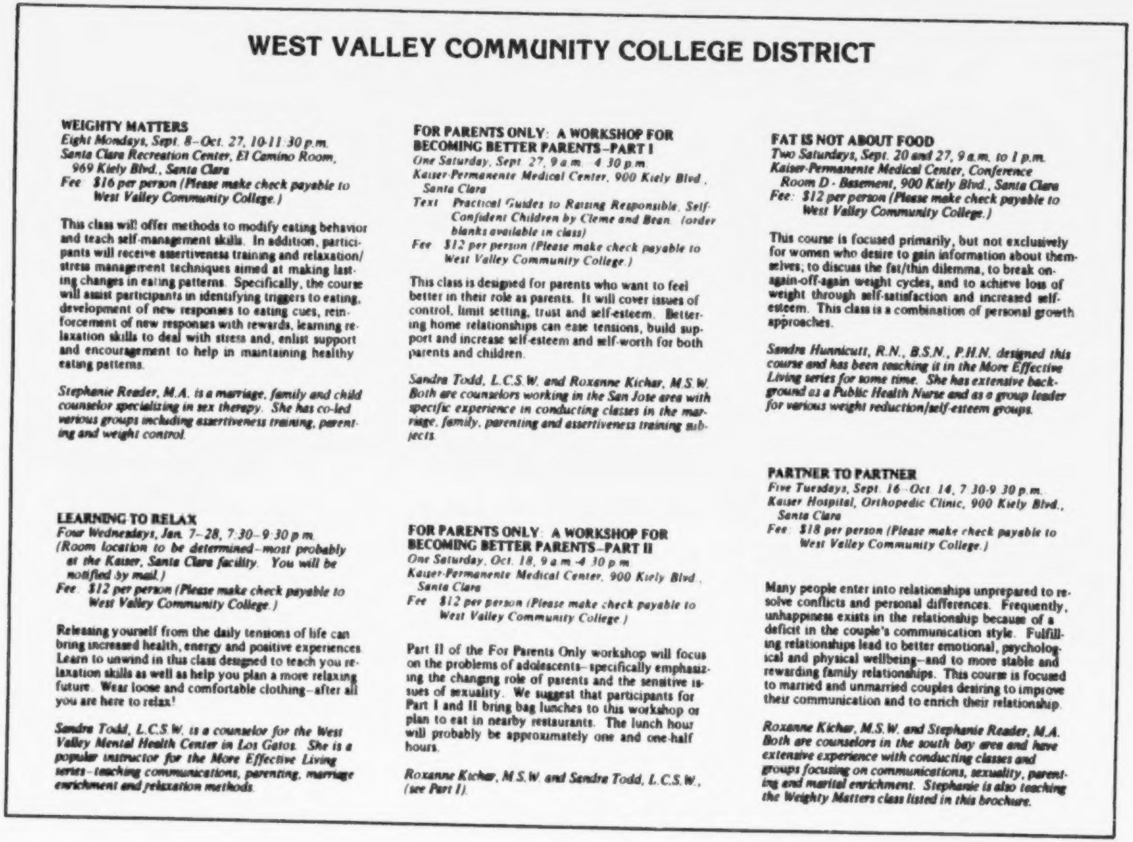
Attended 6 **sessions of a Smoking Cessation Program. ~~Dates attended:~~ 7/20/78 through** 8/24/78. Smoking hx.: 1 pk/day x 20 yrs. Preassessment: Wants to quit b/c of HBP & shortness of breath. Has tried quitting 6 times before by himself. Feels he will have support of family & friends & feels that his motivation is high @ this time. Smoking test reveals that he smokes for "crutch, craving & relaxation" reasons. Very active grp. participant & supportive to others in grp. Results: Quit smoking during 48 hr. trial period with the group betw. sessions 4+5. By conclusion of program still has not smoked. — D. Howard, MPH

9/28 & 10/12/78 F/U sessions attended. Still not smoking. He states he feels like a non-smoker, i.e. "free" of cigs. Providers please reinforce his non smoking status ask him how he's doing. D. Howard, MPH

9/17-10/29/79 Still not smoking after one yr. Participated in Cessation Program as an ex-smoker grp. facilitator D. Howard, MPH

GP-25

Sample Forms and Protocols—Community Program Schedule
Source—Kaiser-Permanente Medical Program, Santa Teresa Medical Center, San Jose, California



WEST VALLEY COMMUNITY COLLEGE DISTRICT

WEIGHTY MATTERS
Eight Mondays, Sept. 8–Oct. 27, 10-11:30 p.m.
Santa Clara Recreation Center, El Camino Room, 969 Kiely Blvd., Santa Clara
Fee: $16 per person (Please make check payable to West Valley Community College.)

This class will offer methods to modify eating behavior and teach self-management skills. In addition, participants will receive assertiveness training and relaxation/stress management techniques aimed at making lasting changes in eating patterns. Specifically, the course will assist participants in identifying triggers to eating, development of new responses to eating cues, reinforcement of new responses with rewards, learning relaxation skills to deal with stress and, enlist support and encouragement to help in maintaining healthy eating patterns.

Stephanie Reader, M.A. is a marriage, family and child counselor specializing in sex therapy. She has co-led various groups including assertiveness training, parenting and weight control.

LEARNING TO RELAX
Four Wednesdays, Jan. 7–28, 7:30–9:30 p.m.
(Room location to be determined–most probably at the Kaiser, Santa Clara facility. You will be notified by mail.)
Fee: $12 per person (Please make check payable to West Valley Community College.)

Releasing yourself from the daily tensions of life can bring increased health, energy and positive experiences. Learn to unwind in this class designed to teach you relaxation skills as well as help you plan a more relaxing future. Wear loose and comfortable clothing–after all you are here to relax!

Sandra Todd, L.C.S.W. is a counselor for the West Valley Mental Health Center in Los Gatos. She is a popular instructor for the More Effective Living series–teaching communications, parenting, marriage enrichment and relaxation methods.

FOR PARENTS ONLY: A WORKSHOP FOR BECOMING BETTER PARENTS–PART I
One Saturday, Sept. 27, 9 a.m.–4:30 p.m.
Kaiser-Permanente Medical Center, 900 Kiely Blvd., Santa Clara
Text: Practical Guides to Raising Responsible, Self-Confident Children by Cleme and Bean. (order blanks available in class)
Fee: $12 per person (Please make check payable to West Valley Community College.)

This class is designed for parents who want to feel better in their role as parents. It will cover issues of control, limit setting, trust and self-esteem. Bettering home relationships can ease tensions, build support and increase self-esteem and self-worth for both parents and children.

Sandra Todd, L.C.S.W. and Roxanne Kichar, M.S.W. Both are counselors working in the San Jose area with specific experience in conducting classes in the marriage, family, parenting and assertiveness training subjects.

FOR PARENTS ONLY: A WORKSHOP FOR BECOMING BETTER PARENTS–PART II
One Saturday, Oct. 18, 9 a.m.-4:30 p.m.
Kaiser-Permanente Medical Center, 900 Kiely Blvd., Santa Clara
Fee: $12 per person (Please make check payable to West Valley Community College.)

Part II of the For Parents Only workshop will focus on the problems of adolescents–specifically emphasizing the changing role of parents and the sensitive issues of sexuality. We suggest that participants for Part I and II bring bag lunches to this workshop or plan to eat in nearby restaurants. The lunch hour will probably be approximately one and one-half hours.

Roxanne Kichar, M.S.W. and Sandra Todd, L.C.S.W., (see Part I).

FAT IS NOT ABOUT FOOD
Two Saturdays, Sept. 20 and 27, 9 a.m. to 1 p.m.
Kaiser-Permanente Medical Center, Conference Room D - Basement, 900 Kiely Blvd., Santa Clara
Fee: $12 per person (Please make check payable to West Valley Community College.)

This course is focused primarily, but not exclusively for women who desire to gain information about themselves; to discuss the fat/thin dilemma, to break on-again-off-again weight cycles, and to achieve loss of weight through self-satisfaction and increased self-esteem. This class is a combination of personal growth approaches.

Sandra Hunnicutt, R.N., B.S.N., P.H.N. designed this course and has been teaching it in the More Effective Living series for some time. She has extensive background as a Public Health Nurse and as a group leader for various weight reduction/self-esteem groups.

PARTNER TO PARTNER
Five Tuesdays, Sept. 16–Oct. 14, 7:30-9:30 p.m.
Kaiser Hospital, Orthopedic Clinic, 900 Kiely Blvd., Santa Clara
Fee: $18 per person (Please make check payable to West Valley Community College.)

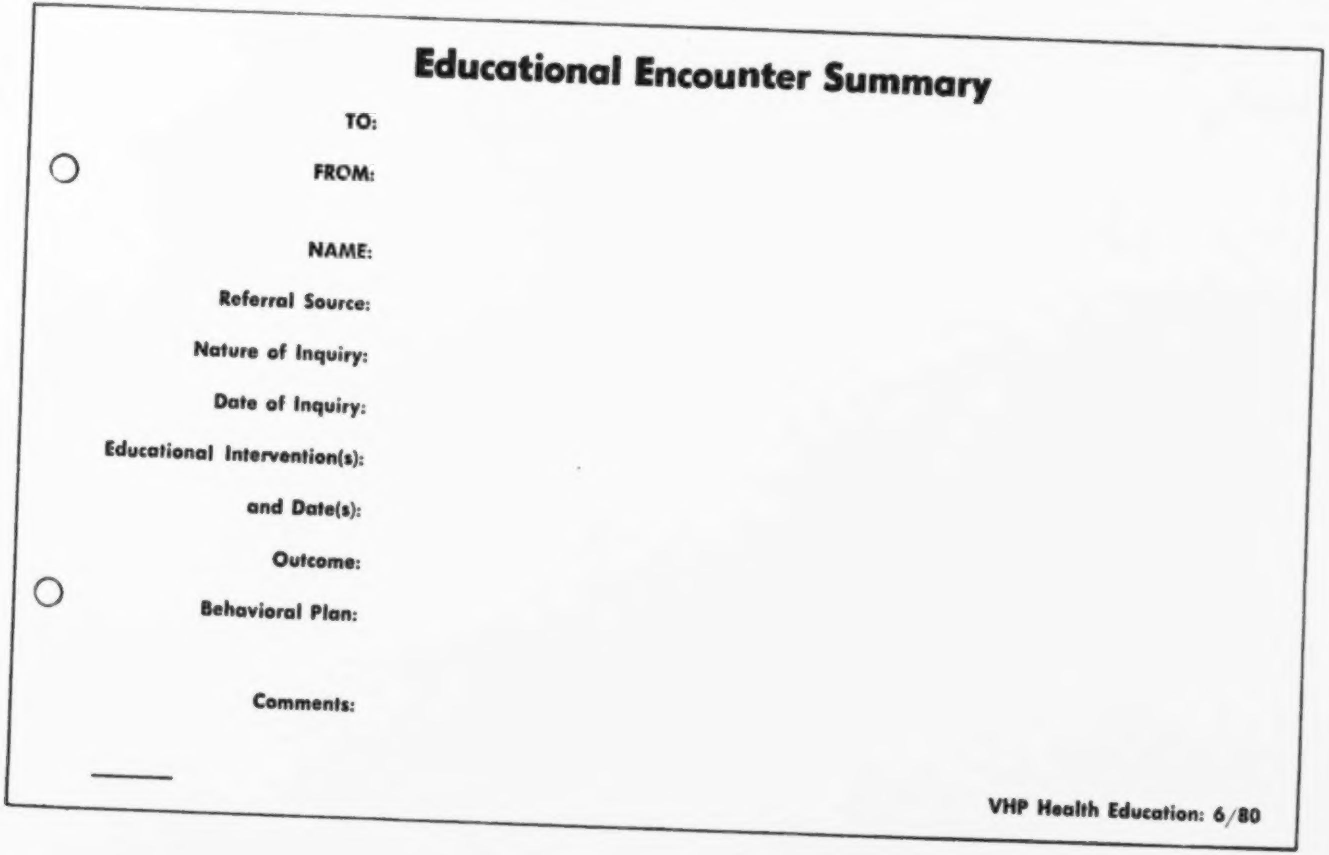
Many people enter into relationships unprepared to resolve conflicts and personal differences. Frequently, unhappiness exists in the relationship because of a deficit in the couple's communication style. Fulfilling relationships lead to better emotional, psychological and physical wellbeing–and to more stable and rewarding family relationships. This course is focused to married and unmarried couples desiring to improve their communication and to enrich their relationship.

Roxanne Kichar, M.S.W. and Stephanie Reader, M.A. Both are counselors in the south bay area and have extensive experience with conducting classes and groups focusing on communications, sexuality, parenting and marital enrichment. Stephanie is also teaching the Weighty Matters class listed in this brochure.

Sample Forms and Protocols—Medical Record Forms

- Educational Encounter Summary

Source—Valley Health Plan, Amherst, Massachusetts



Educational Encounter Summary

TO:

FROM:

NAME:

Referral Source:

Nature of Inquiry:

Date of Inquiry:

Educational Intervention(s):

and Date(s):

Outcome:

Behavioral Plan:

Comments:

VHP Health Education: 6/80

Sample Forms and Protocols—Program Monitoring Forms

- Smokers' Liberation

Source—Adapted by Valley Health Plan From The Guidelines for Research on the Effect of Smoking Cessation Programs: A Committee Report. New York, National Interagency Council on Smoking and Health, October 1974.

SMOKERS' LIBERATION

Participant Demographic Data

Program	Participants (#)			VHP		Student	Student Dependent	Other Area Residents	Mean Age of Participants	Marital Status	
	Total	Male	Female	AMA	UHS					Married	Non-Married
All Enrolled											
Completed Program											
Drop-outs											

Sample Forms and Protocols—Report Forms

- Health Education Department Encounter Record

Source—Comprehensive Health Services of Detroit, Michigan

CHSD

HEALTH EDUCATION DEPARTMENT
ENCOUNTER RECORD

Member's Name CHSD H. P. I.D. # Birthdate Telephone

Address City and State Zip Code Facility

1. Type of Encounter:

☐ Member in Person
☐ Phone
☐ Other_______

2. Member Referred by:

☐ Self
☐ Physician
☐ Nurse
☐ Other

3. Reason for Encounter:

☐ Information
☐ Group Session
☐ Individual Session
☐ View Audiovisual

4. Responding to Recruitment Efforts:

☐ Yes
☐ No
☐ N/A

NATURE OF CONCERN:

INTERACTION/ACTION TAKEN:

FINAL DISPOSITION:

HEALTH EDUCATION REPRESENTATIVE'S SIGNATURE

____

MEMBER'S SIGNATURE____________________DATE_______

SMOKERS' LIBERATION (Continued)

Participant Smoking Habit History

Program	Mean Age Start Smoking	Mean Length of Smoking Habit (yr.)	Daily Amount Cigarettes Smoked (# participants)				Parental Smoking Habits				Previous Cessation Attempts			
			0-20	21-40	41-60	61+	Neither Smoked \#	Father Only \#	Mother Only \#	Both Smoked \#	Never	1x	2x	3x
All Enrolled														
Completed														
Program														
Drop-outs														

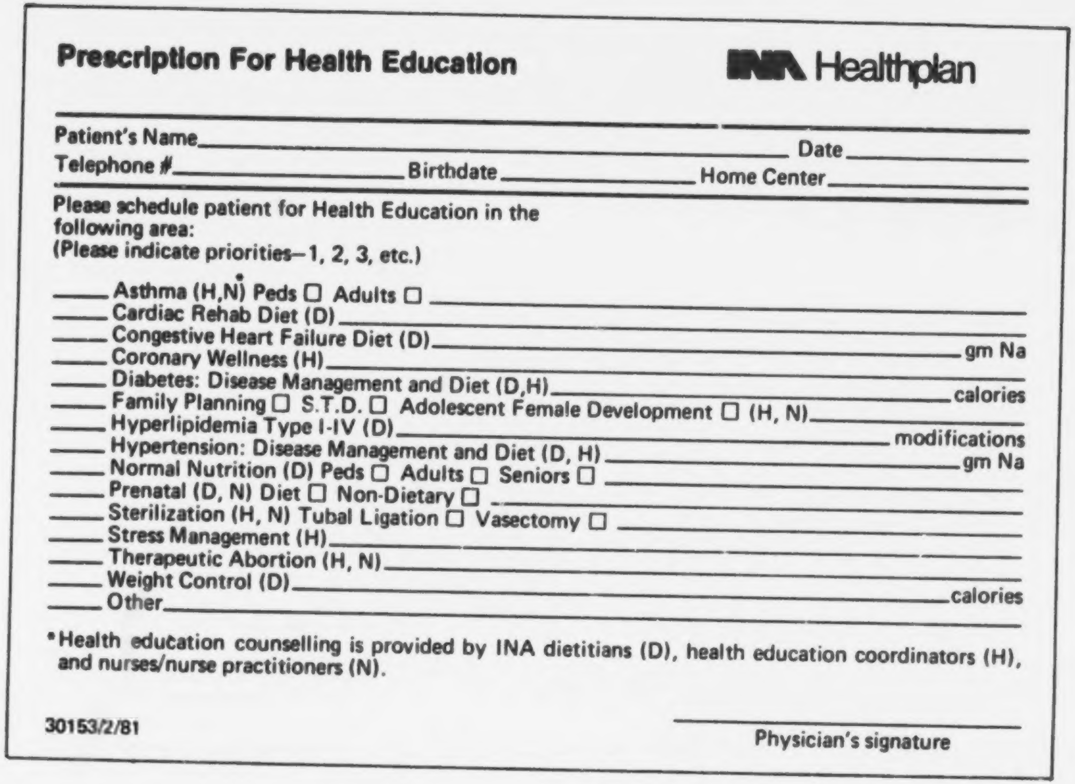
SMOKERS' LIBERATION (Continued)

Mean Daily Consumption at Baseline and End of Treatment and Percent Reduction in Smoking at End of Treatment by Category

Baserate Daily Consumption	Mean Daily Consumption (# cigarettes)		Number of Subjects	End of Treatment: Percent Reduction					
	Baseline	End of Treatment		100% quit	75-99%	50-74%	15-49%	14% less or incr.	No Information
Very light smoker 1-4									
Light smoker 5-14									
Moderate 15-24									
Heavy 25-34									
Very heavy smoker 35+									
TOTAL									

Sample Forms and Protocols—Referral Forms
- Prescription for Health Education

Source—INA Health Plan of California, Los Angeles, California



Prescription For Health Education INA Healthplan

Patient's Name ____________________ Date ________

Telephone # ____________ Birthdate ____________ Home Center ________

Please schedule patient for Health Education in the following area:
(Please indicate priorities—1, 2, 3, etc.)

____ Asthma (H,N)* Peds ☐ Adults ☐ ____________
____ Cardiac Rehab Diet (D) ____________
____ Congestive Heart Failure Diet (D) ____________ gm Na
____ Coronary Wellness (H) ____________
____ Diabetes: Disease Management and Diet (D,H) ____________ calories
____ Family Planning ☐ S.T.D. ☐ Adolescent Female Development ☐ (H, N) ____________
____ Hyperlipidemia Type I-IV (D) ____________ modifications
____ Hypertension: Disease Management and Diet (D, H) ____________ gm Na
____ Normal Nutrition (D) Peds ☐ Adults ☐ Seniors ☐ ____________
____ Prenatal (D, N) Diet ☐ Non-Dietary ☐ ____________
____ Sterilization (H, N) Tubal Ligation ☐ Vasectomy ☐ ____________
____ Stress Management (H) ____________
____ Therapeutic Abortion (H, N) ____________
____ Weight Control (D) ____________ calories
____ Other ____________

*Health education counselling is provided by INA dietitians (D), health education coordinators (H), and nurses/nurse practitioners (N).

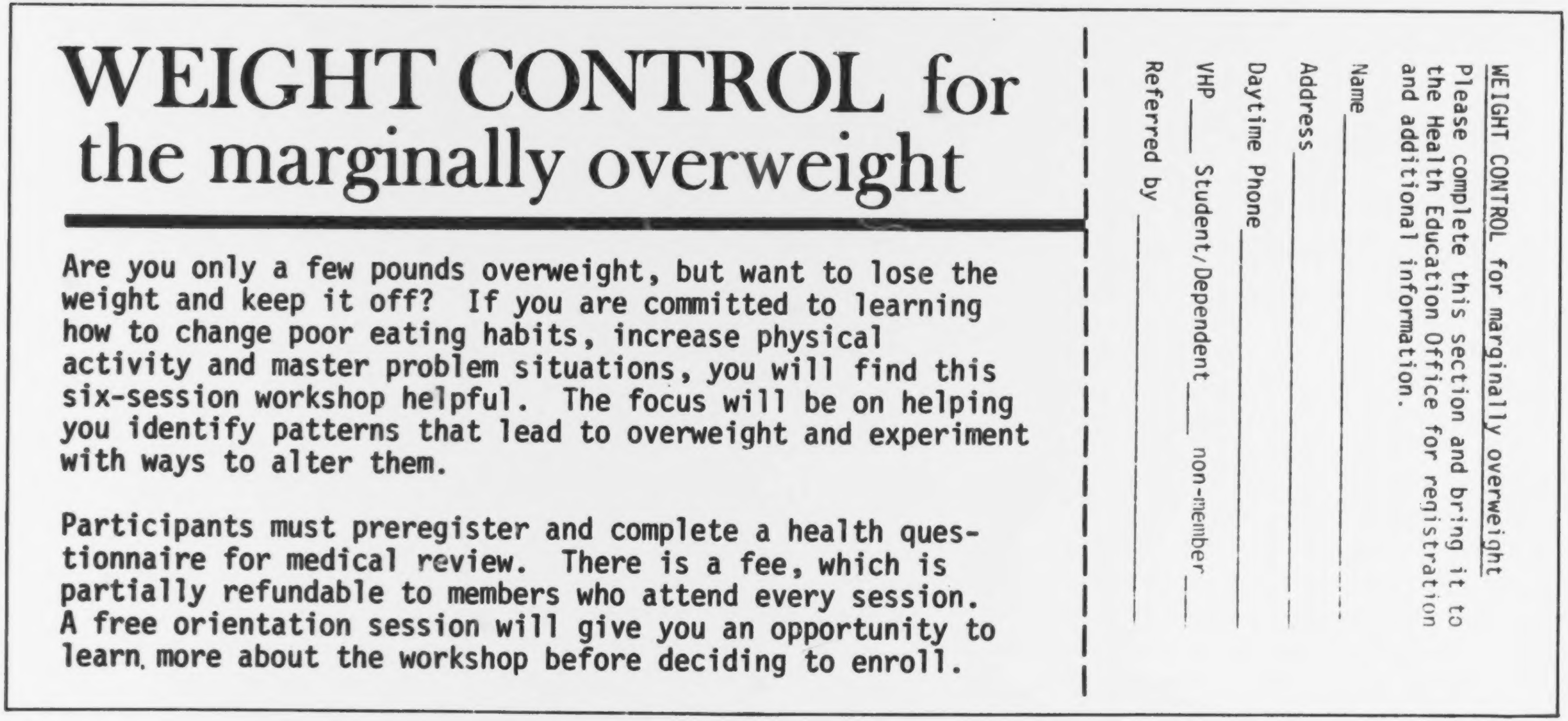
30153/2/81

____
Physician's signature

Sample Forms and Protocols—Referral Forms

- Clinician/Self-Referral Card

Source—Valley Health Plan, Amherst, Massachusetts



WEIGHT CONTROL for the marginally overweight

Are you only a few pounds overweight, but want to lose the weight and keep it off? If you are committed to learning how to change poor eating habits, increase physical activity and master problem situations, you will find this six-session workshop helpful. The focus will be on helping you identify patterns that lead to overweight and experiment with ways to alter them.

Participants must preregister and complete a health questionnaire for medical review. There is a fee, which is partially refundable to members who attend every session. A free orientation session will give you an opportunity to learn more about the workshop before deciding to enroll.

WEIGHT CONTROL for marginally overweight

Please complete this section and bring it to the Health Education Office for registration and additional information.

Name ________________

Address ________________

Daytime Phone ________________

VHP ___ Student/Dependent ___ non-member ___

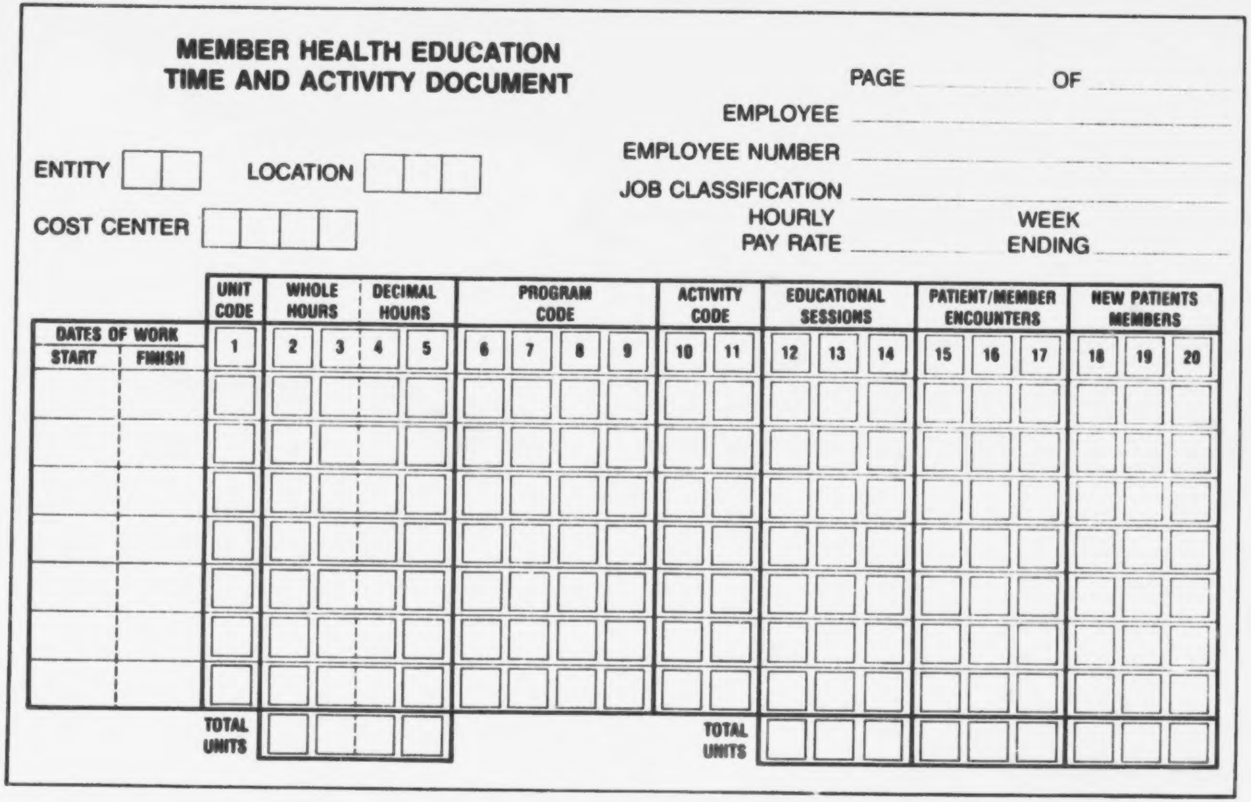
Referred by ________________

Sample Forms and Protocols—Report Forms

- Member Health Education Time and Activity Document

Source—Southern California Permanente Medical Group, Los Angeles, California

NOTE: Completion key not included.



MEMBER HEALTH EDUCATION
TIME AND ACTIVITY DOCUMENT

PAGE ______ OF ______

EMPLOYEE ______

EMPLOYEE NUMBER ______

JOB CLASSIFICATION ______

HOURLY PAY RATE ______ WEEK ENDING ______

ENTITY ☐☐ LOCATION ☐☐☐

COST CENTER ☐☐☐☐

DATES OF WORK		UNIT CODE	WHOLE HOURS		DECIMAL HOURS		PROGRAM CODE				ACTIVITY CODE		EDUCATIONAL SESSIONS			PATIENT/MEMBER ENCOUNTERS			NEW PATIENTS MEMBERS		
START	FINISH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
		TOTAL UNITS									TOTAL UNITS										

Sample Forms and Protocols—Cost Analysis Report

- Cost Analysis Annual Report

Source—Genessee Valley Group Health Association, Rochester, New York

COST ANALYSIS ANNUAL REPORT*

Breast Self Exam (existing program): Options are (1) continue as is with more publicity and outreach or (2) explore other alternatives.

Reasons to Continue

- Determined important by Early Detection Committee.
- Recent research suggests BSE may be helpful in early detection (NEJM, Aug. 10, 1978).
- BSE is not being taught by individual providers as much as Early Detection Committee has recommended (chart reviews 1977 and 1978).

Reasons to Discontinue

- Outreach costs

Sample Forms and Protocols—Course Evaluation Forms
- Weight Control Workshop—Participant Evaluation

Source—Valley Health Plan, Amherst, Massachusetts

Name____________________

WEIGHT CONTROL WORKSHOP

Participant Evaluation

As noted in our contract with you, evaluation is an important and necessary part of this program. Some of the best insights into how to improve the workshop come from you, the participant. Your thoughtful, candid responses to the following questions are appreciated!

1. What three changes have you made during the course of this workshop that have had a positive impact on your weight loss efforts?
   A.
   B.
   C.

2. What has been new or different during this workshop about your weight control efforts compared with past efforts?

3. How do you feel about your progress during the workshop?

4. Since the beginning of the workshop, what events in your life other than the workshop do you feel helped and/or hindered your weight control efforts?

5. During your usual daily routine, are you:

   __Not very active? __Moderately active? __Very active?

   Please explain:

6. In a typical week:
   A. On how many days do you exercise?__0 __1–2__3–4 __5–7
   B. What activities do you include?
   C. For how long do you exercise each time? About__ minutes.
   D. Do you exercise:__Lightly? __Moderately? or __Strenuously?

7. Please complete the following statements, referring to changes you have made related to weight control since the beginning of the workshop.

I have started to________________________

I have stopped ____________________________________

I do these things more often: ______________________

I do these things less often: ____________ _________

I still do these things, but differently: _____________________

8. If any of the behavior changes you have practiced are becoming easier for you (more of a "habit"), please list them here:

9. Please circle the extent to which you agree or disagree with the following statements:

SA = Strongly Agree
A = Agree
N = Neither Agree nor Disagree
D = Disagree
SD = Strongly Disagree

A.	I know how to plan a well-balanced diet.	SA A N D SD
B.	I feel I have the skills I need to control my weight.	SA A N D SD
C.	I feel motivated to lose/control my weight.	SA A N D SD
D.	I would describe myself as a physically active person.	SA A N D SD
E.	I feel good about myself.	SA A N D SD
F.	My important friend/family members are supportive of my weight control efforts.	SA A N D SD
G.	I doubt that I will ever reach/maintain my desired weight.	SA A N D SD
H.	I often eat while doing other things (i.e., reading, watching TV, etc.)	SA A N D SD
I.	I only eat as much as I need to satisfy my hunger.	SA A N D SD
J.	Food is almost always on my mind.	SA A N D SD
K.	I respond to stressful situations by eating and/or drinking too much.	SA A N D SD
L.	I eat very quickly.	SA A N D SD

M. What I eat often includes "sweets" (i.e., sugary desserts, sweetened beverages, candy). SA A N D SD

N. Frequently, when I start eating, I have trouble stopping. SA A N D SD

O. I can't resist food when others are eating. SA A N D SD

P. At least 3 times in an average week, I engage in moderate exercise. SA A N D SD

Q. I am willing to make permanent habit changes that contribute to weight loss/control. SA A N D SD

10. Now that the workshop is ending, what methods do you plan to use to achieve and/or maintain your desired weight loss?

11. What other skills or kinds of support do you feel you need in order to to successful in controlling your weight from now on?

Elaboration on any of the above questions or reflections you would like to share are welcome:

At what address/phone can we reach you three months from now?
Address:______________________________
Phone: Do you prefer to be called during the day___or in the evening?___(Check one.) Phone Number:

THANK YOU!

Sample Forms and Protocols—Course Evaluation Forms
- Instructor Evaluation

Source—Comprehensive Health Services of Detroit, Michigan

CHSD

DEPARTMENT OF HEALTH EDUCATION

INSTRUCTOR EVALUATION

NAME OF INSTRUCTOR______________________________

TITLE OF CLASS______________________________

DATE OF CLASS______________________________

NAME OF EVALUATOR______________________________

CONTENT

1. Was the content of the presentation thorough and complete?

   ___ Yes ___ No

   COMMENTS: ______________________________

2. How well was the presentation planned and organized?

   ___ Acceptable ___ Needs Improvement

   COMMENTS: ______________________________

3. Did the instructor appear to be well prepared for the presentation?

   ___ Yes ___ No

   COMMENTS: ______________________________

4. Were objectives given orally or written to the audience and evaluator, by the instructor?

___ Yes ___ No

COMMENTS: ______________________________

TEACHING TECHNIQUE

5. How well did the instructor make efficient use of the allotted time?

_____ Presentation was well adapted
_____ Presentation was too long
_____ Presentation was too short

COMMENTS: ______________________________

6. To what extent were teaching aids used like, audio-visual equipment, posters, handouts, etc.?

___ Reasonable Amount ___ Not at All

COMMENTS: ______________________________

7. Did the instructor attempt to encourage class participation during the presentation?

___ Yes ___ No

COMMENTS: ______________________________

8. How well was the instructor able to relate his delivery to the audience's educational, cultural, and social level?

__ Reasonably Well __ Needs Improvement __ Not at All

COMMENTS: ______________________________

DELIVERY

9. Did the instructor speak clearly and concisely?

___ Yes ___ No

COMMENTS: ______________________________

10. Was the subject-matter understandable as delivered?

___ Yes ___ Sometimes ___ No

COMMENTS: ______________________________

11. Was a concern for the audience and the subject-matter evident in the instructor's presentation?

___ Yes ___ No

COMMENTS: ______________________________

12. In what manner did the audience respond to the instructor's presentation?

___ Interest ___ Indifference ___ Boredom

COMMENTS: ______________________________

*U.S. GOVERNMENT PRINTING OFFICE : 1982 0-365-843/481

COST ANALYSIS ANNUAL REPORT (Continued)

NAME	PROGRAMS	PARTICIPANTS	ENCOUNTERS	COST		COST/ SERVICE	REVENUES	NET COST/ SERVICE
				PERSONNEL	MATERIALS			
BSE (1 session)	6	43	43	12 hrs @ $10	postage $100			
				27 hrs @ $ 5	xerox $ 50			
				$ 255	$150			
						$9.42	$33	$8.65
				TOTAL = $405				

Smoking Cessation (existing program): Recommend continuation with higher fees

Reasons to Continue

- High interest by members
- High on Health Education Advisory priority list.
- Quit rate is 30% of all who attended at least one session.
- Large number of non-member participants.

Reasons to Discontinue

- Two other community programs exist. However, one costs over 300 and the other is held at different times of the year.

COST ANALYSIS ANNUAL REPORT (Continued)

				COST				
NAME	PROGRAMS	PARTICIPANTS	ENCOUNTERS	PERSONNEL	MATERIALS	COST/ SERVICE	REVENUES	NET COST/ SERVICE
Smoking	3	31	103+	68 hrs @ $10 20 hrs.@ 0 (volunteer)	folders $8 postage $45 xerox $40			
				$680	$93	$7.50	$501	$2.64
				TOTAL = $773				

*Adapted from Health Education Department budget report, 1979.